

Adriel Rest Home Limited

Introduction

This report records the results of a Surveillance 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:	Adriel Rest Home Limited	
Premises audited:	Adriel Resthome	
Services audited:	Dementia care	
Dates of audit:	Start date: 7 December 2015	End date: 7 December 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:	32	

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

General overview of the audit

Adriel Rest Home Limited operates a 42 bed rest home dementia facility in North Canterbury. Services are provided in two houses on adjacent sites – the well-established Adriel Rest Home and the newer Adriel House completed in 2014. This routine unannounced surveillance audit was carried out as a condition of the current certificate. On the day of audit, 32 residents occupied the two homes. There have been no changes to the facility since the previous audit.

The service continues to demonstrate commendable elements above the required levels of performance in its continuing implementation of the ‘Spark of Life’ programme for residents with differing levels of cognitive ability and functioning. In particular, this is having a positive impact with residents with limited communication.

At the certification audit completed in April 2014, four areas for improvement were identified. At this surveillance, one new area requires improvement, and one previous improvement request now meets requirements. There are three areas not yet fully addressed which relate to documentation of informed consent, enduring power of attorney and associated forms, monitoring of the effectiveness of restraint minimisation strategies and the currency of the infection control manual.

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.		Some standards applicable to this service partially attained and of low risk.
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Communication processes are upheld and supported by ongoing training for staff through in-service training, Aged Care Education training and the Spark of Life training. Staff were observed to be considerate of residents' needs and to take the time to ensure appropriate communication.

The previous area for improvement related to informed consent requires ongoing work around processes on the enduring power of attorney (EPOA) documents to ensure these are always dated and the correct signatories are in place.

There have been few complaints at Adriel Rest Home and the service demonstrates that the complaints process meets the requirements of the Code of Health and Disability Services Consumers' Rights (The Code). Documentation and processes support the right to complain and the processes are followed to address and then close out complaints. Staff were conversant with the requirements in receiving and handling complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Adriel Rest Home has planned, coordinated and appropriate services in place. A business plan for 2015 details the scope, direction and goals of the facility. There is evidence of monthly review and monitoring of progress against each aspect of the business plan.

Reviews and results are tabled at the monthly quality meeting with outcomes and trending documented for all staff to read. The monthly quality meeting agenda has standing agenda items for all key areas to ensure every area is constantly actioned, reviewed and relevant data is trended. There is suitable documentation recording outcomes and changes. There is evidence of auditing, ongoing quality improvement activities, risk and adverse event monitoring, with good recording in all areas. Residents, staff and families are involved in aspects of the quality and risk management activity as appropriate. Staff reported awareness of the quality activities and confirmed that the monthly quality meeting minutes are circulated for all staff to read.

An improvement in the development of an action plan to capture and track opportunities for improvement has proved effective and addresses this previous shortfall.

Employment documentation demonstrates a safe process for screening and ongoing review of staff qualifications, experience and ongoing training and review. Staff reported they enjoyed working at Adriel Rest Home and that they felt the staffing levels were appropriate to the needs of the residents. There is a documented rationale for staffing levels which meets contractual and residents' requirements.

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.
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Service provision is well coordinated with interRAI assessment, planning and review evident for all residents. The registered nurse owner maintains detailed plans of care, including where behaviour monitoring is required. Interim care plans detail care requirements when residents' needs change between the scheduled reviews. Implementation to meet specific needs, such as falls minimisation and skin pressure area risks, occurs consistently. Evaluations are completed six monthly using the interRAI assessment framework.

Planned activities are focussed around the Spark of Life programme which continues to impact positively on resident function and communication and exceeds the requirements of the Standard. Activity plans are detailed and individualised. One-on-one and group activities structured around resident abilities are delivered seven days a week by a diversional therapist and assistants specifically trained to implement the programme.

Medicines are being managed safely according to policies, procedures and guidelines for permanent residents, however an area for improvement relates to processes for reconciliation of medicines for residents admitted for short term respite care. Staff administering medicines are trained in the procedures and have current competencies.

A six weekly menu cycle operates from the two kitchens. Food is prepared and served in accordance with recommended food safety guidelines. Staff have been trained in safe food service as part of the Aged Care Education programme.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Adriel Rest Home is designed with a physical environment that minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents. Residents are able to traverse internal and external areas with ease.

Buildings, plant and equipment meet the requirements of legislation to provide a safe environment for residents.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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The facility has sound restraint and enabler planning in place. These are well documented and reflect the aim for restraint minimisation and safe practice. Documentation is detailed and covers assessment, monitoring, evaluation and review as required. The restraint / enabler list includes locked doors, personal restraint, bed rails, lazy boy with foot rest up.

Consultation with resident (where suitable), family members, general practitioners (GPs), and relevant staff occurs to support the assessment process. The registered nurse has responsibility for the restraint minimisation process and oversees all episodes. There is evidence of ongoing training for all staff and staff report an emphasis on the use of calming and de-escalation techniques in the first instance and this has proved to be most effective.

The recording of some interventions is not always transferred from the restraint reporting form to the resident's progress notes. This previous area identified for improvement has yet to be addressed in all instances.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Surveillance of infection is undertaken each month for a variety of infection types, with analysis of data, comparison and trending evident for the two homes. Results are reported to staff at the staff meetings and discussed in depth at the quality meetings held each quarter. At the previous audit, not all policies and procedures were dated or reflective of current infection control terms and principles. Although some updating has occurred, this requires further work to reflect the requirements of the standard.

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	1	16	0	3	1	0	0
Criteria	1	40	0	3	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 1.1.10: 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>	PA Low	<p>Residents and where appropriate their family are provided with the information they need to make informed choices and give informed consent. There is evidence of resident and family involvement in the development and ongoing review of residents' care plans.</p> <p>Some progress has been made in meeting the documentation requirements in relation of enduring power of attorneys (EPOAs). Further refinement of the documents is required to fully meet this criterion. Examples include inclusion of dates and the resident and/or EPOA designation on the informed consent.</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>An appropriate complaint policy and associated documentation are in place and meets the requirements of Right 10 of the Code of Rights.</p> <p>Complaints are documented and followed through to meet the timeframes of the Code. Complaints are tabled at the monthly quality meeting with actions and results detailed. There is evidence of trending of data being undertaken. This meeting is minuted and minutes circulated to all staff to ensure there is learning from any complaint event. There have been six complaints to date in 2015. The two most recent complaints were reviewed in detail and demonstrated due processes had been followed and satisfactory outcomes achieved.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Staff interviewed confirmed there is open communication between residents and family members which is delivered in a manner appropriate to the residents' understanding. Staff were observed taking time to ensure when communicating with residents that they are understood and residents have time to answer. For a resident who is hard of hearing some communication is in written form. For a resident with poor vision, verbal communication and physical guidance, where required, is utilised.</p> <p>There are two residents for whom English is not their first language. Both are reported to be fluent in English and interpreters are not required. The RN verified the facility has not needed to access interpreter services, and was conversant with the processes and contacts in place should these be required as detailed in the policy manual.</p> <p>Residents and / or family, where appropriate, are involved at all levels of decision making in regard to residents' goals and care plans. There is a monthly residents' meeting where residents can raise any questions. These meetings and the subsequent outcomes are minuted (sighted).</p> <p>Staff have ongoing training in good communication via in-service training, the Aged Care Education (ACE) programme training and Spark of Life training.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The facility's 2015 strategic plan lists scope, direction and goals for the year. Three areas (goals, risk management, restraint) are reviewed and reported at the monthly quality meeting. There is evidence of scheduling and changes made following review processes. The minutes and annotations on the strategic plan evidenced this process. The minutes are circulated to all staff.</p> <p>The facility is owned and operated by a registered nurse with 32 years nursing experience who holds a current practising certificate. She has 15 years' experience in managing rest homes.</p> <p>The rest home manager has been an enrolled nurse for three years following a career in caregiving. She holds a current practising certificate and holds a national certificate in caregiving in which she has worked for more than 30 years. She has recently undertaken a two-day management course and is guided by the owner operator.</p> <p>Both the owner/operator/registered nurse and the senior caregiver / new manager felt confident the management process is managed through this allocation of duties.</p>
<p>Standard 1.2.3: Quality And Risk</p>	<p>FA</p>	<p>The facility has an established and documented quality and risk management system which reflects</p>

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>the quality improvement activities undertaken. Documentation is clearly constructed and well completed. Annotations on the risk management plan reflect ongoing review and amendment of risk levels where effective quality improvement has been achieved.</p> <p>The quality plan is supported by an audit schedule which was up to date and with transfer of areas requiring improvement to an action plan which captures identified short falls being addressed. There is evidence of analysis and actioning of findings.</p> <p>The risk management plan demonstrates ongoing review and updating, with recording of changes in risk ratings and actions undertaken. This shows a reduction in risk levels during 2015. Management discussed increased confidence in management of risks and the progress achieved in risk level reduction.</p> <p>The facility holds a monthly quality meeting and the minutes reviewed demonstrated discussion of quality and risk management activities, complaints, adverse events and other quality issues. The minutes also table the outcome and closure of quality improvement activities. There is a register of quality improvement activities which reflects progress of each event over time until closure.</p> <p>The quality meeting has a standing agenda which includes policy review (annual updates spread over the year), records document control updating for the month under review and demonstrates analysis and summaries of progress. These minutes are circulated for all staff to read. Staff confirmed these minutes are made available.</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>	FA	<p>Adverse, unplanned or untoward events are recorded and acted upon. Progress is monitored and reported at the monthly quality meeting. Involvement of family is sought and recorded where appropriate and summaries of outcomes detailed. There is evidence of trending of results and exploration of new methods to address ongoing issues. The minutes are circulated to all staff.</p> <p>The facility is aware of their reporting obligations where required and the first contact is made via the Canterbury District Health Board CDHB (eg, a recent staff injury was reported).</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</p>	FA	<p>Professional qualifications are validated with current practising certificates sighted. Five of thirty-five staff files were reviewed, and demonstrated recorded interview processes, reference checks, annual performance reviews and ongoing training. Police checks are not currently available for all staff but a well-structured approach is in hand with applications for nine of 35 staff currently without a police check on file being systematically applied for. Applications and a schedule for completion were sighted and police checks will now be undertaken at time of appointment.</p>

<p>legislation.</p>		<p>There is a documented orientation programme in place which covers the essential components of the service, and in every instance this process was completed. A separate check of performance reviews shows 26 of the 35 being up to date. There is a schedule for reviewing the remaining nine staff over the rest of the month. Two were scheduled for the day of the audit.</p> <p>It is a requirement that all caregivers complete the ACE caregiver and ACE dementia training programme in the first 12 months of employment. Two staff are now receiving accelerated guidance to complete this training to meet the 12-month timeframe. Staff interviewed confirmed they received a high level of in-service training and were confident in the delivery of care required by the residents of Adriel Rest Home. Recent training included first aid, complaints management, calming and de-escalation, fire training and a range of care training options.</p> <p>All staff interviewed confirmed they received a good level of training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The facility ensures staffing levels are appropriate to the requirements of the residents of Adriel Rest Home. There are predetermined rosters which ensure safe staffing levels at all times. Nearly all staff hold current first aid certificates and there is always at least one person on duty with a first aid qualification. The registered nurse is on call 24 hours a day seven days a week. In the event of her absence a local registered nurse is available if required.</p> <p>A senior caregiver has transitioned to the manager role under the guidance and oversight of the owner-operator. She has recently undertaken a two-day management course and stated she was building confidence in her new role. Her new job description confirms these changes.</p> <p>Clear processes for staffing are detailed in the 2015 strategic plan and address staffing levels and required skill mix for each shift. Staff interviewed stated they felt the staffing levels were appropriate on all shifts.</p> <p>A review of the residents' meeting minutes did not evidence any concern from residents in regard to staffing levels or delays in waiting for cares / attention.</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>PA Moderate</p>	<p>Overall, medicines are being managed safely according to policies and procedures that follow legislative requirements and best practice guidelines, with the exception of medicines reconciliation. Appropriate prescribing by the local GP practice, dispensing by the contracted pharmacy, administration by competent care staff, three monthly review by the GP, locked storage and disposal through return of unused or out of date stock to Pharmacy occurs. Staff report receiving training on the "five R's" at orientation and I annual competencies. Audits are used to monitor</p>

		compliance with policy. No residents self-medicate in this secure dementia facility.
<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>Residents' nutritional and fluid needs are adequately met through a dietitian reviewed summer and winter menu. The menu is currently due for review. Meals are produced from two separate kitchens – one in each house. Food is prepared by night staff and cooked and served to residents by staff trained in food handling via the Aged Care Education programme.</p> <p>Food is attractively served, with quantities and availability of snacks reflective of the needs of active residents over the 24-hour period. Modified textures are prepared as residents require, personal preferences are recognised, and/or alternatives offered. Special dietary requirements addressed where required.</p> <p>Food is delivered or brought on site by approved suppliers. Both food storage and serving temperatures are routinely monitored and recorded. One fridge in Adriel House is recording occasional marginally high temperatures on hot days, but otherwise all fridges and freezers are within range. This aberration was brought to the attention of the manager.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Appropriate care interventions are noted for residents. Examples included the use of hip protection underwear in accordance with the organisation's falls prevention policy. One resident has a wound care plan developed and implemented in response to a low grade pressure injury. Staff are able discuss individual resident care requirements, including blood glucose monitoring for diabetic residents. This is supported by documentation. Mobility interventions are described in the care plan and seen to be implemented with residents. A family member interviewed describes appropriate care interventions occur consistently to meet the individual needs of their spouse.</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>	CI	<p>The Spark of Life programme is now well established and continues to offer residents the opportunity to improve function and memory within their current abilities through the input of staff trained in delivering this person centred care approach. Residents can access either home through the garden areas and describe this as "going to the neighbours". Pets and animals are accessible to residents. Residents who are able also routinely go out to the community accompanied by staff and volunteers to participate in community events, visit a café or other rural events. The activities programme is implemented seven days a week over an extended period of the day to meet the specific needs of dementia residents. A family member comments positively on the varied programme.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The service delivery plans developed using the interRAI assessment process are evaluated six monthly. All file samples reviewed were current or shortly due for review. Where residents' needs change between reviews, an interim care plan is in place as evidenced in resident files reviewed. This forms the basis of the updated care plan where the changed needs are seen to be ongoing. Care plans are consistently maintained and updated appropriately by the Registered Nurse to meet contractual requirements. Care staff record progress at least daily in progress notes.</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 buildings, plant and equipment comply with legislation. A current building warrant of fitness for each building was sighted with an expiry date of April 2016. There are no steps at doorways. Floors and external areas are flat and free from flaws and meet the needs of the residents for safe accessibility and movement. There are secure areas with push button coded access. Chemicals are labelled and stored in a secure area. A current fire evacuation plan is in place. The building compliance certificate was sighted. The Hazard Certificate is current with expiry date of 2017.</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>	PA Low	<p>The infection prevention and control manual has been reviewed since the previous audit. It would also benefit from review and alignment of indexing, page numbers and headings for improved staff use. There are still examples where current good practice is not reflected in the documentation or out of date information is included.</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</p>	FA	<p>The Enrolled Nurse maintains infection control records for the surveillance programme. Surveillance is routinely undertaken each month on key infections relevant to a long term care facility. Analysis of data occurs, infections noted on the infection control summary sheet, and comparison and trending is then undertaken for both homes. Results are reported to staff at the staff meetings (sighted in meeting minutes) and discussed further at the quality meetings held each quarter (sighted most November meeting). Monthly results are variable between the houses, however, overall, no definite</p>

infection control programme.		trends are evident or where these occur, are seen to relate to an individual resident. Residents who are symptomatic with a suspected infection or without laboratory confirmation, as well as those residents receiving antimicrobial therapy, are recorded in the system.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint minimisation policy in place with supporting forms. The focus is on restraint / enabler use reduction and methods to achieve restraint minimisation. Safe practice processes are documented, monitored, evaluated and reviewed as required to maintain residents' safety where necessary. Staff receive annual update training on restraint minimisation with a strong focus on use of calming and de-escalation techniques. The use of restraint or enablers is only introduced where resident safety necessitates such use and the least restrictive option is used. It is noted the use of enablers has not been undertaken at Adriel Rest Home in the period since the last certification audit.</p> <p>Five of thirty-two residents have restraint plans in place following the assessment process. In each case the restraint undertaken is holding of hands or arms while personal cares are undertaken. Records show only two of these five residents have required use of personal restraint during the three weeks preceding this audit.</p> <p>Family/EPoA and GP involvement in the assessment process and ongoing reviews is recorded.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>There is an updated policy and supporting documentation which reflects approval, types and support of restraint / enabler processes. The registered nurse has oversight of safe restraint practice and oversees and reviews all events. Responsibility for this function is detailed in the registered nurse current job description.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in</p>	FA	<p>Use of restraint / enablers is overseen by the registered nurse who is the facility owner. It is noted there has been no use of enablers since the last certification audit. The assessment process is thorough and involves consultation with GPs, family members, the resident where this is suitable; and relevant caregiver staff. Consideration is made of any potential or identified risks and exploration of the contributing behaviours and other relevant factors. The assessment process is</p>

relation to use of restraint.		documented and reviewed. Restraint / enabler use is audited and the results are tabled and discussed at the monthly quality meeting with discussion documented and circulated for all staff to read. Staff interviewed were aware of the recording requirements for use of restraint / enablers and confirmed they receive calming and de-escalation training and individualised training relevant to each resident's needs where use of restraint / enablers is required.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Low	Staff are trained and updated annually in calming and de-escalation techniques. Staff confirmed they found the training timely and effective. If further interventions are required, staff stated they are shown techniques relevant to required assistance for each affected resident. Oversight of every restraint / enabler episode is made by the registered nurse. The restraint records showed full completion of documentation in each instance. Recording of each use of restraint against the restraint plan is required in the progress notes. This was on occasion not clearly documented or difficult to locate.

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 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Low	<p>Previously, documentation for informed consent, enduring power of attorney and forms relating to end of life wishes were not being completed according to legislative requirements and best practise. Practices around informed consent and related processes were not consistent with documented policies and not all policies met legislative requirements. At this audit, policies have been updated to meet the requirements, however forms remain confusing and do not reflect best practice.</p>	<p>Further refinement of the documents is required to fully meet this criterion. Examples relate to inclusion of dates and the resident and/or EPOA designation on the informed consent form. Files sighted refer to the residents completing the consent form but the nominated EPOA has signed it in each case.</p>	<p>Ensure the informed consent form for admission and care reflects the person and their status is clearly documented and dated to reflect</p>

				180 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>All aspects of prescribing by local GP's, dispensing by the contracted pharmacy, administration completed and records maintained by competent care staff, three monthly medicines review by the GP, locked storage and disposal through return of unused or out of date stock to Pharmacy occurs consistently. Medication requiring refrigeration is segregated and fridge temperatures records maintained within the required range. There are currently no controlled drugs held at Adriel, however the register is maintained and stock checked as required when any drugs are held on site.</p> <p>There is a system to reconcile blister packed medication delivered from the Pharmacy, with records maintained showing this does occur at each cycle of delivery. In the medication records reviewed, one resident has recently been approved for long term placement following several months of respite care. The usual process for reconciliation of medication has not occurred for this resident and there is a discrepancy noted at audit between the medication order and the content of the blister pack. Medication has been administered to the resident by staff during this extended period and this discrepancy has not been identified or addressed. Family have been responsible for obtaining the medications from the pharmacy and bringing it to the facility in this period.</p>	<p>One resident has recently been approved for long term placement following several months of respite care. The usual process for reconciliation of medication has not occurred and there is a discrepancy noted at audit between the medication order and the content of the blister pack. Medication has been administered by staff during this period and this discrepancy has not been identified or addressed. Family have been responsible for obtaining the medications from the pharmacy in this period</p> <p>The usual processes for managing residents' medication and reconciliation has not occurred for one resident receiving respite care. A discrepancy is noted at audit between the order generated by the GP practice and the content of the blister pack supplied by family. Medication has not been administered in accordance with the Adriel Rest Home policies and procedures or Ministry of</p>	<p>Ensure that the medication management system includes a reconciliation process consistent with policy and guidelines, including for any residents receiving respite care.</p> <p>90 days</p>

			Health Guidelines.	
<p>Criterion 3.3.1</p> <p>There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.</p>	PA Low	<p>The owner manager describes how she oversees the infection control manual which has been reviewed to reflect more consistent terminology. She reports the processes for review and where necessary, updating staff through the staff meetings when policies or procedures change. However, there remain examples in the manual where current good practices are not clear (eg, the surveillance criteria in Long Term Care document is not current and the infection control advisor has changed since the manual was amended).</p>	<p>Although the infection control manual has had some review since the previous audit, there remain aspects which require updating to align with current accepted practices and contact detail.</p>	<p>Review and update the infection prevention and control manual to reflect current good practice and up to date contact information.</p> <p>180 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the</p>	PA Low	<p>Use of restraint is included in care planning but is not clearly documented in the resident's progress notes when a restraint event has occurred.</p>	<p>The transfer and entry of information is delayed or overlooked in resident progress notes.</p>	<p>Ensure timely and clear recording of information in the resident's progress notes.</p> <p>180 days</p>

consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.				
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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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The registered nurse owner is a trained Spark of Life Practitioner and trainer. The programme is improving both resident relationships and communication through practical implementation of the essence of Person Centred Care at both group and individual levels. Its effectiveness is monitored for each resident and the programme modified according to individual responses. One resident has improved their verbal communication after their individualised programme was implemented. The programme enables residents to change between the groups which ensures they can maximise their abilities with the best level of support.</p>	<p>The Spark of Life programme is fully integrated into day to day life of residents in the facility. All staff spoken to are aware of the benefits of the programme, which is implemented by a trained diversional therapist and health care assistants. The nurse manager is also a trained diversional therapist who has received specific training in the Spark of Life programme in Australia. She is a certified trainer. The residents have improved function, communication and memory within their functional abilities through the input of staff trained in delivering person centred care. One participating resident has regained some verbal communicating again after a period of aphasia. This demonstrates sustained achievement beyond the expected fully attained rating. The group programme has been developed and refined, with a variety of activities such as exercise sessions. An individualised plan is evidenced for one resident who walks for extended periods, particularly when feeling stressed or anxious. Encouragement of this activity has been an effective strategy to reduce difficult behaviours.</p>

End of the report.