

Tairua Residential Care Limited - Tairua Residential Care

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand 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:	Tairua Residential Care Limited
Premises audited:	Tairua Residential Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 February 2016 End date: 12 February 2016
Proposed changes to current services (if any):	This audit has verified the service as suitable to provide hospital (medical) level of care.
Total beds occupied across all premises included in the audit on the first day of the audit:	41

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

Tairua Residential Care provides rest home and hospital level care for up to 44 residents. On the day of audit there were 41 residents. This audit also included verifying the service as suitable to provide hospital (medical) level of care.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, family, management, staff and a general practitioner. The owner is also the manager of the facility. She is a registered nurse who is appropriately qualified and experienced. She is supported by a team of nine registered nurses.

Improvements are required around the analysis of quality data and feedback to staff of quality results; developing corrective action plans where indicated; interRAI assessments; wound and pressure injury assessments and care plans; medication management; first aid/CPR training; equipment calibration and testing; restraint assessments and monitoring the use of restraint.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with dignity and respect. Written information regarding consumers' rights is provided to residents and families during the admission process. The residents' values and beliefs are assessed on admission and are being met by the service. Examples of good practice were evident. Residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

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.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated and are appropriate to the needs of the residents. Annual business goals are documented with evidence of regular reviews. Quality and risk data is regularly collected and collated. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. All new staff undergo a period of orientation. Regular education and training is in place for staff. Registered nursing cover is provided 24 hours a day, seven days a week. The residents' files are appropriate to the service type.

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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Initial assessments and care plans are completed by the registered nurses. Residents and family interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. A general practitioner reviews each resident at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

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.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts. There is sufficient space to allow the movement of residents around the facility using

mobility aids. The communal areas are spacious and accessible. There is wheelchair access to all areas. The outdoor areas are safe and easily accessible. The service has an approved fire evacuation scheme. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. Appropriate training, information and equipment for responding to emergencies are provided. Housekeeping staff maintained a clean and tidy environment. Toilet/shower facilities are constructed for ease of cleaning. Personal laundry is completed on site but sheets and towels are laundered offsite by a contractor.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definition in the restraint minimisation standard. The service had three residents in the hospital assessed as using a restraint and seven residents voluntarily using an enabler. A register is maintained by the restraint coordinator. Residents using restraints are reviewed six-monthly at a minimum. Staff regularly receives education and training in restraint minimisation and managing challenging behaviours.

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.

The infection control coordinators (owner/manager and a registered nurse) monitor the infection rates and are responsible for coordinating education and training for staff. The infection control coordinators have attended external training. There are infection control policies and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control coordinators inform staff of infection rates at the monthly staff meeting.

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	41	0	5	4	0	0
Criteria	0	90	0	6	5	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>There is an implemented policy on residents' rights to guide practice. Discussions with care staff (four caregivers who work the morning and afternoon shifts in the rest home and hospital, three registered nurses (RNs) and two activities coordinators) confirmed their understanding of the Code of Health and Disability Consumers' Rights (the Code). Interviews with seven residents (two hospital level and five rest home level) and three relatives (one with family at rest home level of care and two with family at hospital level of care) confirmed the service is provided in line with the Code. Staff training on the Code begins during their orientation to the service and continues regularly as an in-service topic.</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>Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement and additional consents are signed by the resident or their enduring power of attorney (EPOA). The admission agreements are signed on admission. Advanced directives are signed for separately. The caregivers and the registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussions with family</p>

		members identified that the service actively involves them in decisions that affect their relative's lives. All seven residents' files sampled contained appropriately signed consent forms and advance directives.
<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	Residents are provided with information on the Code and advocacy services during their entry to the service. Brochures are available at the entrance, alongside complaints forms. Interviews with the owner/manager and staff described how residents are informed about advocacy and support. Residents and families identified that the service involves them in decision-making. They confirmed that they are aware of their right to access advocacy support.
<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	All relatives interviewed stated they could visit at any time and that they are encouraged to be involved with the service and care. Visitors were observed coming and going during the audit. The activities programme encourages links with the community. A van is used for regular outings. Interviews with the residents confirmed that staff encourages them to maintain their links with their family and the community.
<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 complaints procedure is provided to residents and relatives during entry to the service. A record of all complaints is maintained by the owner/manager using a register. Three complaints received in 2015 were reviewed and reflected evidence of responding to each complaint in a timely manner with appropriate follow-up actions taken. All three complaints are documented as resolved.</p> <p>The number of complaints received is minuted in the staff meetings (link to 1.2.3.6).</p> <p>Discussions with residents and families confirmed they were provided with information on complaints during their entry to the service. Complaints forms and a suggestions box are located in a visible location at the entrance to the facility. Residents and families confirmed that they are comfortable speaking with the owner/manager if they have a concern and that concerns are dealt with promptly.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The Code posters and brochures are displayed in public areas of the facility. The information pack given to prospective and admitted residents and their families includes pamphlets on the Code and the

		Health and Disability Advocacy Service. The admission agreement contains information relating to consumer rights. Interviews with residents and family confirmed that consumer rights were explained during the admission process. They also confirmed that resident's rights are being upheld by the service. Monthly residents' meetings provide opportunities to discuss aspects of the Code.
<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>There is an implemented policy supporting the privacy of residents. Residents' rooms are single, private rooms. Consent processes and visual privacy are upheld. Privacy signage and locks are on toilet and shower doors. Discussions with residents and relatives confirmed their privacy is respected with examples provided.</p> <p>The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Information that is relevant is gathered during the entry process and is sufficient to support the individual needs of the residents. A satisfaction survey is carried out annually to gain feedback.</p> <p>Residents are supported and encouraged to maintain their independence; confirmed in interviews with residents and care staff. A physiotherapist is used as needed.</p> <p>The abuse/neglect policy includes definitions and the process for reporting to ensure resident safety. Abuse and neglect training is included in the staff education and training programme. Discussions with the owner/manager and staff identified that there have been no reported incidents of abuse or neglect. Staff understand that they are to report any concerns.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Māori cultural policies are in place. Consultation was previously with a local kaumatua who is no longer available and has been replaced with input from two staff who identify with their Māori culture. There were no residents who identify as Māori. Discussions with staff confirmed their understanding of the cultural needs of residents, including the importance of involving whānau in the delivery of care.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's</p>	FA	<p>A culturally appropriate service is provided, which includes assessing resident's needs on admission. Individual values and beliefs are</p>

<p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>identified through assessment and care planning processes. Family are invited to be part of the care planning process and are provided the opportunity to be involved in all aspects of care delivery. Interpreters are available if needed. There were no residents at the facility where English was their second language. Families and residents interviewed expressed their satisfaction with the services that the residents are receiving.</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>Policies outline the service's responsibilities to ensure residents are not subjected to discrimination, coercion, harassment and sexual or other exploitation. Education and training is provided to staff (beginning during their orientation to the service), including professional boundaries, code of conduct, abuse and neglect and residents' rights. Professional boundaries are assessed in staff performance appraisals.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. The owner/manager and staff interviewed confirmed their commitment to meet the needs of their residents. Registered nursing staff are available seven days a week, 24 hours a day. Residents identified as stable are reviewed by the general practitioner (GP) every three months with more frequent visits scheduled for those residents whose condition is not deemed stable.</p> <p>The service receives support from the Waikato District Health Board. A physiotherapist is utilised on an as needed basis.</p> <p>There is a monthly in-service education and training programme for staff. Staff competency assessments are implemented. All caregiver staff receive supervision by the RNs.</p> <p>The service has maintained strong links with the local community and encourages their active residents to remain independent. Residents interviewed spoke positively about the care and support provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies and procedures relating to accident/incidents and open disclosure identify staff responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on a TIS ('towards improving service') form. Fifteen accident/incident forms that were reviewed across the rest home and hospital identified family are kept informed. Family</p>

		<p>interviewed stated that they are kept informed when their family member's health status changes.</p> <p>Contact details of available interpreters are available. Staff and family assist as they are able. The information pack is available in large print and is read to residents who require assistance.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement.</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>	FA	<p>Tairua Residential Care has been owned and managed by a registered nurse for the past 10 years. The service has 44 beds; 31 at rest home level and 12 at hospital level. This audit has verified the service as suitable to provide hospital (medical) level of care. At the time of the audit the facility was occupied with 31 residents receiving rest home level care and 10 residents receiving hospital level care. Forty residents were on the Aged Related Care (ARC) Contract and one (hospital level) resident was on the Young Persons with Disability Contract. One rest home resident was receiving palliative care and three rest home level residents were receiving respite care.</p> <p>A philosophy and values are defined and a current business plan is in place that includes measurable goals. Goals are regularly reviewed by the owner/manager. Plans are being developed to build a dementia wing.</p> <p>The owner/manager is a registered nurse with a current practising certificate who has worked in aged care for many years. She is supported by a team of nine registered nurses, one who is second in charge.</p> <p>The owner/manager has maintained a minimum of eight hours annually of professional development related to managing an aged care service.</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</p>	FA	<p>During the temporary absence of the owner/manager, a designated second in charge/registered nurse covers the owner/manager's role.</p>

<p>the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk 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>PA Low</p>	<p>The quality and risk management programme is guided by a monthly schedule that identifies policies for review, internal audits scheduled, and staff appraisals due. Interviews with the owner/manager, care staff and one cleaner, one laundry staff, one cook and one maintenance staff reflected their understanding of the quality and risk management programme.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are reviewed annually. They have been updated to include reference to interRAI for an aged care service.</p> <p>Data collected (eg, falls, medication errors, wounds, skin tears, challenging behaviours, complaints) are collated with numbers reported at staff meetings. Meeting minutes did not reflect any analysis of this data.</p> <p>Internal audits are completed as documented in the audit schedule. Areas of non-compliance were not minuted in staff meeting minutes. Corrective action plans are sometimes missed where an audit reflects a need for improvement.</p> <p>Falls prevention strategies include identifying residents who require mobility equipment and ensuring supervision is in place for those residents who require assistance. Staff investigate falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. Low beds and sensor mats are utilised.</p> <p>A health and safety programme is in place. A health and safety representative has been identified. Hazard identification forms and a hazard register are in place. Staff orientation includes health and safety. Internal audits linked to health and safety are regularly conducted.</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>Individual reports are completed for each incident/accident with immediate action noted including any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme (link to 1.2.3.6). Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse.</p> <p>The owner/manager is aware of the responsibility to notify relevant authorities in relation to essential notifications.</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>	FA	<p>Human resources policies address recruitment, orientation and staff training and development. Seven staff files (four caregivers, two registered nurses and the cook) that were randomly selected for review included evidence of signed employment contracts, completed orientation and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed stated that new staff are adequately orientated to the service. Current annual practising certificates were sighted for the registered health professionals.</p> <p>There is an annual education and training schedule that exceeds eight hours per annum. Training is well attended by staff. Education and training for registered nursing (RN) staff is supported by the Waikato District Health Board. Two RN's have completed their interRAI training. Chemical safety training is in place. Staff trained in first aid/CPR training are available onsite but not when taking residents on outings (link to 1.4.7.1). Staff are competent to provide hospital (medical) level of care.</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>	FA	<p>The staffing levels meet contractual requirements. The owner/manager is an RN who is available during weekdays. Additional RN cover is provided 24 hours a day, seven days a week. RNs are supported by sufficient numbers of caregivers. Interviews with the residents and relatives confirmed staffing overall was satisfactory.</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>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support</p>

		<p>plan is developed in this time.</p> <p>Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in secure areas. Archived records are stored securely in a locked room on the premises.</p> <p>Individual resident files demonstrate service integration.</p> <p>Entries are legible, dated and signed by the relevant caregiver or registered nurse and include the time of entry and the staff member's designation.</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>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The owner/manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical coordinator. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</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>	FA	<p>There are policies in place to ensure the discharge of residents occurs safely. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</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>	PA Moderate	<p>Medications are administered by registered nurses and senior caregivers. These staff have completed annual medication competencies and medication education. One RN interviewed was able to describe her role in regard to medicine administration. The RN was observed administering medications safely. There were five self-</p>

		<p>medicating residents at the time of the audit. None of the five had a current competency assessment. The RN in charge did not check that these residents had taken their medication as prescribed each shift. Medications were securely and appropriately stored. The service has standing orders to be administered on the orders of the RN. The policy states that the GP is to be informed if any resident has a standing order medication administered for more than 24 hours. Standing orders medication protocol was not followed as per facility policy and GP orders.</p> <p>The facility uses a blister pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medication charts are written correctly by medical practitioners and there was evidence of three-monthly reviews by the GP.</p> <p>Fourteen medication profiles reviewed (ten rest home and four hospital) were legible and charts evidenced photographs documented. Medication profiles reviewed consistently evidenced that allergies were documented and that the GP had reviewed the resident's medications at least three monthly. 'As required' medication consistently evidenced indications for use. Five medication profiles evidenced that medications were given as prescribed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the cook works closely with the RN and care staff. The kitchen staff have completed food safety training. The cook stated at interview that the menus are reviewed by a dietitian and documented evidence of this was viewed on the day on the audit. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded daily. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were happy with the quality and variety of food served.</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 consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents, should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed on admission and were reviewed at least six monthly or when there was a change to a resident's health condition in six of seven files sampled. Care plans reviewed were developed on the basis of these assessments for five of seven files sampled (link 1.3.6.1). Pain and continence assessments (where applicable) were in place in the files reviewed. InterRAI assessments are on-going. There have been four residents admitted since 1 July 2015 (all directly from DHBs). Three of four new admissions did not have a completed interRAI assessment within 21 days of admission. One resident who was reassessed as requiring hospital level of care did not have an interRAI assessment completed on their return from hospital.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Five of seven long term care plans reviewed described the interventions required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings (link 1.3.6.1). Residents and their family/whānau are involved in the care planning and review process. Short term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.</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>	PA Moderate	<p>Dressing supplies are available and a treatment room/cupboard is stocked for use. Continence products are available and residents' files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management.</p> <p>Wound assessments and comprehensive wound management plans were not in evidence for pressure injuries and wounds present on the day of the audit.</p>

		<p>Registered nurses (RNs) and caregivers follow the care plan and the RN's report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral. If external medical advice is required this will be actioned by the GP. Specialist continence advice is available as needed and this could be described.</p> <p>Care plan interventions included regular turns which were documented in the progress notes. Care plan interventions included turns (which were evidenced in the progress notes), monthly weights and weekly pain assessments.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service has two activities coordinators who both work full time. One is based in the hospital and one is based in the rest home. Shared activities are planned and all residents are invited to attend activities in either area. The service has a five day weekly programme and activities were observed occurring. In addition to the week day activities volunteers attend on Saturday's to provide bowling for the residents. Every Sunday there is a Catholic communion service held. On-on-one time occurs on an individual basis for those residents who choose not to participate in activities. There is a variety of activities provided. A van is available for residents' outings. Residents enjoy weekly outings and shopping trips. Community links are maintained with groups and individual visitors. A church service is held every Monday. There is a residents' meeting held monthly. Copies of the meeting minutes are available for residents and a copy is placed on the notice board. A yearly satisfaction survey is completed where feedback on activities is obtained.</p> <p>Each resident file sampled had an individual activities assessment completed on admission; this is used to formulate an individual activity care plan which is reviewed six monthly or as required.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Moderate	<p>All initial care plans were evaluated by the registered nurse within three weeks of admission in files sampled. In two of seven files sampled care plans were reviewed by the RN six monthly or when resident's needs changed (three residents had not been at the service for 6 months). There was at least a three monthly review by the GP in these files. Care plan reviews are signed by the RN in files sampled. Short term</p>

		care plans were evaluated and resolved or added to the long term care plan if the problem is on-going in resident files sampled. Care plans are not always updated where progress is different from expected, the service responded by initiating changes to the care plan.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes.
<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	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.
<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>	PA Low	The building has a current building warrant of fitness. There is a part time maintenance person employed to address the reactive and planned maintenance programme. The medical and electrical equipment had not been serviced and/or calibrated within the last 12 months. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. The facilities and available equipment (once serviced and calibrated) are suitable and sufficient to provide hospital (medical) level of care.
<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</p>	FA	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Several bedrooms have their own ensuites. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when

personal hygiene requirements.		staff are undertaking personal cares.
<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>	FA	All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.
<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>	FA	The communal areas include the main lounge and several smaller loungers and two dining areas. The communal areas are easily and safely accessible for residents.
<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>	FA	<p>The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done off site except for personal items which are washed by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service.</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>	PA Low	<p>Appropriate training, information and equipment for responding to emergencies are provided. Fire evacuations are held six monthly. There is a minimum of one staff available onsite 24 hours a day, seven days a week with a current first aid certificate. However, first aid/CPR certificates are not up to date for staff who take residents on outings in the van.</p> <p>Civil defence and emergency policies and procedures are in place. There is an approved evacuation plan. The facility is well prepared for civil emergencies and has emergency lighting. A store of emergency water is kept. There is a gas BBQ for alternative cooking and extra blankets for heating. Emergency food supplies are sufficient for three days. Extra blankets are available.</p> <p>The electronic call bell system that was recently upgraded is available in all residents' rooms, toilets, showers and communal areas. Residents were observed to have access to their call bells. Residents</p>

		interviewed stated their bells were answered in a timely manner.
<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>	FA	General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.
<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>	FA	Tairua residential care has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the owner/manager. Infections are discussed at the monthly staff meetings. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.
<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	A registered nurse at Tairua Residential Care is the designated infection control (IC) coordinator with the support of the owner/manager. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) receive external support from the local laboratory infection control team. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<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	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.
Standard 3.4: Education	FA	The infection control policy states that the facility is committed to the

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>on-going education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The registered nurse is the designated infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly resident infection data sheet and then analysed and evaluated and reported to staff meetings. No corrective actions have been commenced to manage a spike in infections (link 1.2.3.8).</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraints and enablers and restraint procedures. Interviews with the caregiver and nursing staff confirmed their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had six residents voluntarily using bed rails as an enabler. The use of enablers is linked to the resident's care plan with signed consent processes in place. Three residents were using restraints.</p>
<p>Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (owner/manager/RN) and for staff are documented and understood. Restraint procedures identify the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is</p>	<p>PA Moderate</p>	<p>A restraint evaluation tool has been used in place of a restraint assessment tool and assessments were not completed in files sampled. Consultation with the resident and family/whānau are evident with</p>

undertaken, where indicated, in relation to use of restraint.		signed consent sighted for all three hospital level residents where restraint (bedrails) were in place to keep these residents safe.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Low	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints include bed rails, lap belts and fall out chairs. The restraint coordinator (owner/manager) is a registered nurse (RN). The RNs are responsible for ensuring all restraint documentation is completed.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family, the GP and the RN. The use of restraint is linked to the resident's care plans, sighted in all three resident's files. An annual internal audit is conducted to monitor staff compliance in following restraint procedures. Each episode of restraint is scheduled to be monitored at pre-determined intervals depending on individual risk to that resident and is documented in the resident's care plan.</p> <p>Staff are instructed to document evidence of monitoring safe restraint use in the resident's progress notes using a column designated for restraint monitoring. Documented evidence of regular monitoring was not routinely occurring in the residents' files selected for review.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>A restraint evaluation form is in place that covers the aspects of the criterion. Evaluations are scheduled to take place six-monthly as part of the on-going reassessment for the residents on the restraint register and as part of the care plan review. One completed evaluation was used in place of a restraint assessment (link 2.2.2.1). Only one resident has been using a restraint for six months. An evaluation of restraint use was completed for this resident.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraints processes are reviewed annually when the restraint policies and procedures are reviewed by the owner/manager, who is also the restraint coordinator. An annual internal audit is conducted and restraint minimisation education and training for staff is undertaken annually with evidence of the training programme being evaluated.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Adverse event data is collected. The frequency of occurrences is shared with staff but there is no evidence in the meeting minutes to confirm data is analysed. The owner/manager reports that there is discussion but it is not being minuted. Internal audit results are not being minuted in the monthly staff meetings.</p>	<p>Adverse event data is collected with numbers communicated to staff in staff meetings but there is no evidence of the analysis of this data. Staff were not informed of internal audit results in 10 of 12 monthly staff meetings for 2015, evidenced in the monthly staff meeting minutes.</p>	<p>Ensure adverse event data is analysed and internal audit results are routinely communicated to staff.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and</p>	PA Low	<p>Each internal audit report includes documenting findings and recommendations but where results are sub-optimal; a corrective action plan is not routinely developed.</p>	<p>Internal audit results are completed and include a summary that documents findings and recommendations. Missing is evidence of corrective action plans where results reflect the need for improvements and a</p>	<p>Ensure corrective action plans are routinely developed where indicated and there are processes in place to evaluate the effectiveness of corrective actions that</p>

implemented.			process for evaluating corrective action plans.	are developed. 90 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>	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements. Standing order medication was administered nine times over a week before GP was informed	(i) One resident had paracetamol administered as a standing order nine times over a week before the GP was informed. (ii) Nine of fourteen medication charts reviewed reflected medications were not recorded as given as prescribed.	(i) Ensure that GP is informed for all standing order medications given for over 24 hours as per facility policy and (ii) ensure that all medications are given as prescribed. 60 days
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Moderate	Medications for residents who self-administered were stored safely and securely. Five of five residents had a competency assessment completed before self-medication commenced, but these were not reviewed three-monthly and RN's do not check administration.	i) Five of five self-medicating residents did not have a current assessment of their competency and ii) there was no system in place for RN checking that residents had administered their medications each shift.	i) Ensure that all self-medicating residents have a competency reassessment at least every three months and ii) ensure that the RN checks that the resident has taken their medication each shift. 60 days
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	One of four new admissions since 1 July 2015 had an interRAI assessment completed within 21 days of admission and an interRAI assessment was not completed for one resident with a change of level of care. Comprehensive paper based assessments were completed	i) Three of four residents admitted since 1 July 2015 did not have an interRAI assessment completed within 21 days of admission and ii) one resident who was reassessed as requiring hospital level of care whilst in public hospital did not have an interRAI assessment	i) Ensure that all new admissions have an interRAI assessment completed within 21 days of admission and ii) ensure that all residents with a significant change to their health status have

		however. Weekly pain assessments were completed for those files sampled of residents with chronic pain.	completed on their return to the facility.	an interRAI assessment completed. 60 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Wound assessments and comprehensive wound management plans were not in place in 10 of 10 wounds reviewed (excluding pressure injuries). The short term care plan did state the timeframe for review of the wounds. All wounds had been reviewed in the stated timeframe. One of the registered nurses interviewed described the referral process should they require assistance from a wound specialist. Four of four pressure injuries did not have a wound assessment (including correct grading) or comprehensive wound management plan including techniques for pressure reduction or management of pain.</p>	<p>Wound assessments and comprehensive wound management plans were not in place in 10 of 10 wounds reviewed. Four of four pressure injuries did not have a wound assessment or comprehensive wound management plan.</p>	<p>i) Ensure all pressure injuries and wounds have a wound assessment and comprehensive wound management plan.</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Moderate</p>	<p>Short term care plans were in use for changes in resident's health status though for two residents with significant health changes, their care plans had not been updated to reflect their current needs and interventions.</p>	<p>Two residents with significant changes in their health needs have not had their care plans updated.</p>	<p>Ensure that residents care plans are updated to reflect changes in their health needs</p> <p>60 days</p>

<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>A current building warrant of fitness is posted in a visible location (expiry date 22 September 2016). Residents have access to an external area that is shaded and well maintained. The medical and electrical equipment has not been serviced and/or calibrated within the last 12 months. During the audit, the manager arranged for this to occur the following week.</p>	<p>Medical and electrical equipment has not been serviced or calibrated within the last 12 months.</p>	<p>Ensure all medical and electrical equipment is serviced and/or calibrated every 12 months</p> <p>90 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA Low</p>	<p>Staff receive fire and safety training. This begins during their induction to the service and continues as an annual mandatory in-service topic. Fire evacuations are conducted six monthly. There is a minimum of one staff available onsite at all times with a current first aid/CPR certificate. Missing was evidence of first aid and CPR training for staff who take residents on outings.</p>	<p>Ensure a minimum of one staff trained in CPR and first aid is available in the van when taking residents on outings.</p>	<p>Ensure staff who take residents on outings hold a current first aid/CPR certificate.</p> <p>90 days</p>
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the</p>	<p>PA Moderate</p>	<p>A restraint assessment process has not been put into place. One of three residents using bedrails as a restraint had a restraint evaluation form completed as an assessment tool and two residents with bedrails as restraint had no documented restraint assessment in their files.</p>	<p>Restraint assessments were missing in two of three residents where bedrails were being used as a restraint. The RN staff used a restraint evaluation form for the third resident using restraint.</p>	<p>Ensure that a restraint assessment process is completed that covers all aspects of the criterion ((a) – (h)) before any restraint is put into place.</p> <p>30 days</p>

<p>relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>				
<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</p>	<p>PA Low</p>	<p>The care plan includes the schedule for monitoring residents using bedrails as restraint. Staff are instructed to document monitoring residents while restraint is in use in a designated column in the resident's progress notes. Evidence of monitoring is not being documented in a consistent manner.</p>	<p>Monitoring each episode of restraint use was not consistently evident in the three resident's files reviewed.</p>	<p>Ensure residents are monitored while restraint is in use, and that this is documented in the resident's files.</p> <p>90 days</p>

restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.