

# Laama Holdings Limited

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## 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:

<b>Legal entity:</b>	Laama Holdings Limited
<b>Premises audited:</b>	Epsom South Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 14 April 2016    End date: 14 April 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	19

# Executive summary of the audit

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## 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

Epsom South Rest Home provides care for up to 27 rest home level care residents.

This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, management, staff and the general practitioner. No family/whānau were available on the day audit.

There is one area for improvement related to the locked door not being able to open automatically in an emergency. Refer findings 1.4.7.2.

## 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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Epsom South Rest Home implements policy and procedures to ensure complaints are documented, reviewed, followed up and fully addressed. At the time of audit there are no open complaints.

Evidence was seen of open disclosure with residents being informed and given options with all aspects of care.

## 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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Epsom South Rest Home has a business plan which covers all aspects of service delivery planning. The business plan is reviewed annually by the owner/director and senior staff and shows that service planning and coordination occurs to meet the needs of residents.

The owner/director is supported by a nurse manager who is a registered nurse with a current practising certificate. The nurse manager oversees all clinical aspects of care and is supported by staff who are experienced in the age care sector.

The service has quality and risk management systems which are understood by staff. Quality management reviews include internal audits, complaints management, resident and family/whānau satisfaction surveys, resident meetings, restraint monitoring, and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff, residents and family/whānau as appropriate. Corrective action planning occurs as required.

Good human resources practices are implemented. The staffing skills mix is appropriate for rest home care services. Every shift is covered by a staff member who holds a current first aid certificate.

As confirmed during resident interviews all their needs are met by the service.

## 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.



Standards applicable to this service fully attained.

Services are provided by suitably qualified and skilled staff to meet the needs of the residents. The interRAI assessment process is in place and all residents have an interRAI assessment completed. Timeframes for the development and review of long term care plans are met. Short term plans are developed when there are changes in the resident's needs that are not addressed on the long term care plan.

The general practitioner (GP) reviews all residents medically within the required timeframes and more frequently as needed. Pressure injury management and responsibilities are documented in policy and implemented. The nurse manager is fully informed in relation to reporting requirements for any pressure injuries.

There is an employee with dedicated hours to undertake the activities programme. A quality initiative is in place to review and amend the activity programme following feedback from a residents' survey.

A safe medication system was observed during the audit. The staff responsible for medication management have completed comprehensive competencies to perform this role.

The residents' nutritional requirements are met by the service with preferences and special diets being catered for.

## 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 medium or high risk and/or unattained and of low risk.
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The building has a current building warrant of fitness. There have been no changes made to the building footprint since the previous audit.

There is a lock on the front door which is not connected to the fire alarm system for automatic release

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is one resident with restraint in use for safety reasons only. The facility has a key lock on the front door and this environmental restraint is well managed and identified by the service. However, this door cannot open automatically in case of a fire, (Refer comments in 1.4.7).

Policy describes enablers' as being voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the annual education planning process.

## 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>Standards applicable to this service fully attained.</p>
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The infection prevention and control management system is appropriate for the nature of the service. The risk of infection is reduced for residents, staff, families/whanau and visitors.

The nurse manager, who is the infection control co-ordinator, collates the monthly surveillance data and this is sent to a contracted infection control management service for analysis. A report on any trends and actions to be implemented is provided. The infection surveillance results are reported at the staff two monthly meetings. Expertise is available and can be sought as required.

## 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)
<b>Standards</b>	0	16	0	0	1	0	0
<b>Criteria</b>	0	39	0	0	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The service promotes an environment of full and frank information sharing. Policies and procedures are in place if interpreter services are needed.</p> <p>The residents interviewed confirmed they are kept informed of any changes. Evidence is seen of family contact in all residents' files reviewed.</p> <p>The nurse manager (NM) and registered nurse (RN) interviewed understood the principles and practice around open disclosure and that residents have a right to full and frank information. The RN and caregivers have received training and this is documented in the training records and individual staff records reviewed.</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>Complaints management is implemented to meet policy requirements. The complaints register sighted identified the issue, the date received and the date the complaint was closed off. There are no open complaints at the time of audit.</p> <p>The owner/director and nurse manager confirmed complaints management information is used as an opportunity to improve services as required. Complaints processes are explained during the admission process as confirmed during resident interviews.</p> <p>Residents also have monthly meetings where the complaints process is discussed</p>

		<p>and residents are encouraged to verbalise any complaints or concerns they may have. This is confirmed in meeting minutes sighted</p> <p>Staff verbalised their understanding and correct implementation of the complaints process. Complaints are a standing agenda item for staff meetings.</p> <p>No negative comments were made during resident interviews on the day of audit.</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>The organisation's goals and direction are described in the business plan along with the quality and risk plan. Each goal and objective is clearly described and cover all aspects of service delivery. The owner/director and the nurse manager review the goals on a regular basis with a full review being undertaken in January each year to ensure planning is meeting residents' needs. The purpose, value, scope and direction of the organisation are clearly documented.</p> <p>On the day of audit occupancy consisted of 19 rest home level care residents.</p> <p>The owner/director has been in the role for over six years. She is supported by a nurse manager. The current nurse manager has been in the role for four weeks and is being supported by the previous nurse manager who now works reduced hours. The new nurse manager is a registered nurse and has worked in aged care for the past three years.</p> <p>Both the owner/director and nurse manager have attended regular professional educational forums related to the roles they perform. The nurse manager's job description identifies her authority, accountability and responsibility for the provision of services.</p> <p>Resident interviews confirmed that their needs are met by the service.</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>	FA	<p>The quality and risk processes in place include regular internal audits, incident and accident reporting and analysis, restraint monitoring, infection control management and data recording, and complaints management processes that are fully implemented and understood by staff. This was confirmed during interview. If an area of deficit is found corrective measures are put in place to address the situation. Data collected and corrective actions are shared with all staff as confirmed in meeting minutes and verified by staff during interview. The quality data results are reported to staff in a manner that is easily understood and shows comparisons from previously collected data.</p> <p>Policies and procedures are developed by an off-site provider who ensures they are aligned with current good practice and service delivery, meet the requirements</p>

		<p>of legislation and are reviewed at regular intervals. All policies sighted are up to date.</p> <p>Monthly resident meetings are used as one forum to indicate resident satisfaction of services offered. All service delivery issues are discussed and followed up as required. The minutes sighted indicated resident satisfaction with the services offered. This is supported by the annual satisfaction survey results sighted which were collated in March 2016.</p> <p>Quality data information, which includes quality indicators to measure improvements, is used by the service to inform ongoing service planning and to ensure residents' needs are being met. Corrective measures put in place are also evaluated during monthly staff meetings. This is confirmed in meeting minutes sighted.</p> <p>Actual and potential risks are identified and documented in the risk register which covers all aspects of service provision. Newly identified hazards are documented using a specific form to show how the hazard is managed. All hazards are reviewed at least annually and this last occurred in January 2016. Hazards are communicated to staff, family/whānau and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p> <p>Residents interviewed confirmed they are happy with the services provided. Staff verbalised quality improvements and how they have been embedded into everyday practice.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>As per policy, the service records all incidents and accidents on a specific form. Staff interviewed confirmed they report and record all incidents and accidents. Any required follow up is undertaken in a timely manner and is clearly documented. For example, the need to undertake neurological observations for 48 hours following a fall as appropriate.</p> <p>Documentation confirms that information gathered from incidents and accidents is used as an opportunity to improve services where indicated. Incident and accident information is reported at staff monthly meetings as confirmed in minutes sighted.</p> <p>The nurse manager confirmed her understanding related to the obligations in relation to essential notification requirements, including for pressure injuries.</p>

<p>Standard 1.2.7; Human Resources Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.</p> <p>Policies and procedures identify human resources management practices that reflect good employment practice, meet the requirements of legislation and are implemented by the service. Job descriptions describe staff responsibilities and accountabilities. Five staff files reviewed identify that staff have completed an orientation programme with specific competencies for their roles. Annual appraisals are up to date. The owner/director stated that the organisation is to introduce police vetting for any new staff employed. The registration process was confirmed on email.</p> <p>The annual education calendar identified the education undertaken by staff covers all aspects related to care provision. Education included on-site and off-site education. This was confirmed in the education records sighted for all staff.</p> <p>Residents interviewed and satisfaction survey results confirmed that the services delivered met the residents' needs and are performed in a professional manner.</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>Policy related to staff skill mixes and experience is reflected in the roster and meets contractual requirements. Every shift is covered by a staff member with a current first aid certificate.</p> <p>A review of the roster showed that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed they have adequate staff on each shift to allow all tasks to be completed in a timely manner and that residents' needs are met. This is supported by residents interviewed.</p> <p>The owner/director is rostered and works on the floor at least five days a week. There is a registered nurse on duty Monday to Saturday 7am to 3.30pm and on call at other times. The GP also provides on-call services. There are dedicated kitchen staff seven days a week.</p>
<p>Standard 1.3.3: Service Provision Requirements</p> <p>Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.</p>	<p>FA</p>	<p>Each stage of service delivery is undertaken by suitably skilled staff. The nurse manager (NM) and registered nurse (RN) are fully trained in the interRAI assessment process. The registered nurse is responsible for completing the interRAI assessment for all residents on admission, developing the short term care plans, the long term care plan, evaluations and reviews of the care plans. There is involvement of the resident/family and this was evident in the residents' records randomly selected and reviewed.</p>

	<p>The GP contracted to the service conducts all medical assessments and review the resident's condition three monthly or more frequently as needed. The GP was available for interview. Appropriate timeframes for initial assessments and ongoing reviews as per the service agreement with the district health board were met.</p> <p>The residents' records reviewed have initial assessments, social/lifestyle history assessments and goals are set for the resident that identify the physical, psycho-social, spiritual and cultural aspects for each individual resident. Additional assessment tools are available for the resident reviews (e.g., wound care, nutritional status, pressure injury assessment (Waterlow)). Evaluations occur six monthly or earlier if the resident's condition changes. There is evidence that communication with families is maintained.</p> <p>Staff interviewed stated that continuity of care and team work is promoted. System are in place to identify to caregivers any additional cares needed, such as for weekly weighs or residents at risk of falling.</p> <p>Residents interviewed reported satisfaction with the care and services provided. This is supported in staff and resident surveys completed annually reports.</p> <p>Tracer Methodology</p> <p>The resident was admitted from the DHB. A full assessment was undertaken and all protocol was in place for rest home level care. The discharge summary and clinical management was clearly outlined on discharge from the DHB. The interRAI assessment was completed by the registered nurse on admission and the initial and long term care plan was developed and implemented. The GP visits three monthly or more often if required and each visit is documented in the medical records. The Braden Scale for predicting pressure injury risk is completed and a nutritional status assessment as part of the six monthly review process. Family are in close contact. The resident is settled and comfortable and feedback in the records states the family are pleased with the care and services provided. Staff interviewed are informed of the resident's needs. An assessment is being completed for hospital level care as the resident's health is deteriorating. The family reported that they wish him to stay at the rest home while he is able to be cared for safely as he has been there for some time.</p> <p>Pressure injury (PI) information</p> <p>Ω No. of PI on day of audit: [0]</p> <p>Ω Facility acquired PI: [0]</p>
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		<p>Ω Non-facility acquired PI: [0]</p> <p>Ω No. Stage 1 PI: [0]</p> <p>Ω No. Stage 2 PI: [0]</p> <p>Ω No. Stage 3 PI: [0]</p> <p>Ω No. Stage 4 PI: [0]</p> <p>Ω No. Stage 5 (Unstageable (depth unknown)) PI: [0]</p> <p>Ω No. Stage 6 (Suspected deep tissue injury) PI: [0]</p> <p>Ω Assessed level of care: Hospital: [0]</p> <p>Ω Assessed level of care: Rest Home: [0]</p> <p>Ω Assessed level of care: Dementia: [0]</p> <p>Ω Assessed level of care: Psychogeriatric: [0]</p> <p>Ω Assessed level of care: Young person: [0]</p> <p>Component (Yes/No and Comment)</p> <p>Ω PI being treated at the time of the audit: [No] Comment [There are no PIs at the facility]</p> <p>Ω Policy/guideline: [Yes] Comment [The policy is in line with requirements]</p> <p>Ω Internal audit programme: [Yes] Comment [The internal audit programme for 2016 contains audits for pressure injuries]</p> <p>Ω Meeting minutes: [Yes] Comment [Meeting minutes of staff and quality meetings include reference to pressure injuries]</p> <p>Ω Adverse event reporting: [Yes] Comment [This is included in the risk programme]</p> <p>Ω Annual training programme: [Yes] Comment (Pressure injuries are included in the 2016 education programme]</p> <p>Ω Equipment: [Yes] Comment [Available as required]</p> <p>Ω Staff interview: [Yes] Comment [Staff interviewed report knowledge of pressure injuries]</p>
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<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>	<p>FA</p>	<p>Support and care is individualised and focused on achieving desired outcomes/goals set. The registered nurse and care staff interviewed demonstrated appropriate skills and knowledge of the individual needs of all residents. The records reviewed showed evidence of consultation and involvement of the resident and family as able. The residents interviewed reported satisfaction with the care and services provided.</p> <p>Short term care plans are developed and implemented as necessary for any event that is not part of the long term care plan, such as unexplained weight loss or wound care management. The registered nurse ensures the GP is kept well informed of progress.</p> <p>There are adequate stocks of wound and continence products to meet the needs of the residents. The care plans reviewed demonstrated interventions that are consistent with the resident's needs. Observations on the day of the audit indicated residents are receiving care that is consistent with meeting their assessed needs.</p>
<p>Standard 1.3.7; Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme uses a framework to empower the residents to have the opportunity to be valued and respected. The activities coordinator adapts activities to meet the needs and choices of the resident.</p> <p>The facility has one activity co-ordinator who works dedicated hours per week. The hours are flexible and worked within a five day working week (at times including weekends) to allow for different activities and community events occurring.</p> <p>The weekly activities plan/calendar sighted is developed based on the residents' needs and interests and can be easily adapted and changed depending on the residents' interest and reaction at the time. The activity coordinator advertises the upcoming activities on the calendar on the notice boards through the facility. The caregivers assist with the planned activities seven days a week. Regular activities include church services, 'happy hour', regular visiting entertainment and trips to other events occurring in the community. Daily activities occur within the main lounge. The care staff interviewed stated that they have access to activities to support residents after hours and on the weekends.</p> <p>The outside environment provides easy access to outside garden areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements.</p>

		Daily activities attendance sheet records are maintained for each resident. The goals are updated, assessed, reviewed and evaluated in each resident's file six monthly.
<p>Standard 1.3.8.2: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluation of care plans occurs six monthly or earlier as applicable. Evaluations are focused and indicate the degree of achievement or response to support/interventions and progress towards meeting the set goals. If a resident's needs change or if the resident is not responding appropriately to the interventions being delivered then this is discussed with the GP, the resident and the family. Short term care plans are initiated as needed.</p> <p>The care staff interviewed demonstrated good knowledge of short term care plans and reported that these are identified and information is shared in the handover between shifts. Progress is also discussed at the six monthly reviews.</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>	FA	<p>The lunchtime medication round was observed and demonstrated a safe process. The GP was available for interview and the registered nurse can notify the GP with any queries or points of clarification as needed.</p> <p>The medication records randomly selected had been reviewed by the GP and any allergies/sensitivities are entered to alert staff. A system is in place for returning any unused or outdated medication to the contracted pharmacy. These are recorded and monitored.</p> <p>The medication room is in close proximity to the nurses' station and a medication trolley is available and is locked when not in use. There are no controlled drugs on the premises.</p> <p>There are no residents who self-medicate. A self-medication policy is in place.</p> <p>The medication fridge is monitored on a daily basis and the temperatures recorded, which meet requirements.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Policies and guidelines are available. The menu plans have been reviewed by a registered dietitian and a letter is available to verify this has occurred. The cook and kitchen hands have all completed food handling training. The food safety management education is appropriate for service delivery.</p> <p>There are separate cleaning schedules for the kitchen. Temperature monitoring requirements are met. The cook orders all food and checks deliveries, storage and manages the waste management appropriately. All food is correctly labelled. The</p>

		<p>kitchen is clean and functional and is in the centre of the facility.</p> <p>A nutritional assessment is performed by the registered nurse with the resident/family/whanau as part of the admission process. A copy is provided to the cook. Any resident preferences, special diets, likes/dislikes are documented. Special days are celebrated, such as birthdays, and are catered for by the cook and kitchen hands.</p> <p>Annual service satisfaction surveys are completed by residents/family and this includes the food service. The families and residents interviewed reported satisfaction with the meals provided. Fluid rounds, morning and afternoon teas are provided and fresh baking is available. The lunch was served in the dining room. Food is available over 24hours for all residents.</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>Documentation identifies all processes are maintained for the facility's current building warrant of fitness which expires on 29 September 2016. There have been no changes made to the footprint of the building since the previous audit.</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>	FA	<p>This was an additional finding related to the lock on the front door not being connected to the fire alarm to disengage in case of an emergency.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policy clearly describes enablers as voluntary and the least restrictive option to meet residents' needs. The facility has one resident with a bedside rail and chair lap belt in use.</p> <p>There is a locked front door at the facility which is identified in policy and managed safely as an environmental restraint. Assessments, reviews, resident and family/whānau involvement and awareness is clearly recorded as required. All residents have a signed approval to say they are aware of the lock on the door and how to exit. Residents were observed coming and going from the facility throughout the day. The key code is displayed on the punch lock on the door. Interviews with residents confirm they are able to exit the facility whenever they wish and that their family/whānau members also know the code. A discussion held with the nurse manager and the owner/director identified that the service is currently reviewing the use of the locked door and that as it is used for security reasons only it does not</p>

		<p>need to be in used during the day.</p> <p>The locked door is not linked to the fire alarm so that it will open automatically in an emergency. This has been discussed with management and they are aware this is an area for improvement. Refer comments in 1.4.7.2.</p> <p>An annual review of all restraint was undertaken on 10 January 2016. Staff education occurred on 30 January 2016 with 100% staff attendance.</p>
<p><b>Standard 3.5:Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection prevention and control surveillance that is undertaken is appropriate to the size of this aged care setting as demonstrated in the infection control programme. All staff are involved. An infection form is completed as soon as signs and/or symptoms have been identified and given to the registered nurse. Monitoring is described in the infection control plan to ensure residents` safety.</p> <p>The infection prevention and control co-ordinator is currently the NM who completes the monthly surveillance reports. Monitoring occurs for any urinary infections, eye infections, upper and lower respiratory infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections as required. The infection control nurse compares results with previous reports, reasons for any increase or decrease and/or trends are identified. The results are reported back to staff at the staff meetings.</p> <p>There was a scabies outbreak in January 2016 which was documented and appropriately managed.</p>

## Specific results for criterion where corrective actions are required

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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.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. Provide evidence that all compliance issues are met for the evacuation plan to include the opening of the lock on the front door in case of an emergency.	PA Moderate	Discussions with the nurse manager confirm that the front door lock does not automatically disengage when the fire alarm goes off.

