# Oceania Care Company Limited - Lady Allum Rest Home and Village

## 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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Lady Allum Rest Home and Village

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

**Dates of audit:** Start date: 10 May 2016 End date: 11 May 2016

**Proposed changes to current services (if any):** In November 2014 the service applied to HealthCERT for approval of reconfiguration of their certified services, by the use of existing unused rooms to provide additional three hospital/rest home (dual purpose) beds to increase the number of beds from 140 to 143.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 143

# 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 |
|  | 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

Lady Allum Rest Home and Village provides rest home and hospital level care for up to 143 residents. At the time of the audit the facility had full occupancy.

The approval of the reconfiguration of the certified services, by the use of existing unused rooms to provide three additional hospital/rest home (dual purpose) beds was obtained from HealthCERT in 2014, increasing the number of beds from 140 to 143.

This certification audit was conducted against the Health and Disability Service Standards and the service’s contract with the district health board. Included in this report are references to the increase of the three additional beds. The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

The business and care manager is responsible for the overall management of the facility and is supported by two clinical managers and the regional and executive management team. The residents and families spoke positively about the services provided.

A continuous improvement has been attained in infection control.

## Consumer rights

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| --- | --- | --- |
| 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. |

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are provided to residents and their family on admission and displayed throughout the facility. Residents and family members confirm their rights are being met, staff are respectful of their needs and communication is appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission and recorded in the residents’ care plans. The residents and family members are provided with information prior to giving informed consent. Written consent is obtained where required.

The business and care manager is responsible for the management of complaints. The complaints register is maintained and evidences the complaints are managed as per timeframes in the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

## 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. |

Oceania Care Company Limited has a documented quality and risk management system that supports the provision of clinical care and support at the service. Systems are in place for monitoring the services provided, including regular monthly reporting by the business and care manager to the Oceania support office.

The facility is managed by an experienced and suitably qualified business and care manager who is a registered nurse with aged care experience.

There is reporting on various clinical indicators, quality and risk management issues and discussion of any trends identified at the facility’s meetings. Quality improvement data provides evidence that data is being collected, collated and analysed to identify trends. Where required, corrective action plans are developed, implemented and evaluated. There are policies and procedures on human resource management, which are implemented. An orientation programme is conducted by all new staff. There is a mandatory in-service education programme for staff.

The rationale for determining staffing levels and skill mixes in order to provide safe service delivery is based on best practice. Resident information is entered into a register in an accurate and timely manner. The privacy of resident information is maintained.

## Continuum of service delivery

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| --- | --- | --- |
| 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. |

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

Services are provided by suitably qualified and skilled staff to meet the needs of the residents. All residents have had an interRAI assessment performed and these are accessible. Timeframes for the development and review of the person centred 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 plan.

The general practitioners review all residents medically at specified timeframes and more frequently, as required. Referrals to other health and disability services are planned and coordinated, based on the individual needs of the resident.

The activities programme meets the social and recreational needs of the residents. Activities are planned and are meaningful to residents. Residents are encouraged to maintain links with the community and the family/whānau. A safe medication system was observed during the audit. The registered nurses 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. The contracted service prepares all meals and staff are experienced. Menus are approved by the food service manager and a dietitian.

## Safe and appropriate environment

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

There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. The proactive and reactive maintenance programme ensures buildings; plant and equipment are maintained to an adequate standard. All building and plant comply with legislation with a current building warrant of fitness displayed.

Protective equipment and clothing is provided and used by staff. Chemicals and equipment are safely stored. All laundry is laundered off site. The cleaning and laundry systems including appropriate monitoring to evaluate the effectiveness of these services.

Residents' rooms have adequate personal space to provide personal space for residents, and allow staff and equipment to move around safely. Lounges, dining areas and seating alcoves are available. External areas are available for sitting and shading is provided.

An appropriate call bell system is available and security and emergency systems are in place. Information in relation to emergency and security situations is available/displayed for staff and residents. The emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting.

## Restraint minimisation and safe practice

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

The service is committed to restraint minimisation and safe practice. The policy complies with the standard. There are three restraints in use and three enablers. The enablers are voluntary and aid independence. Written consents were on each resident’s record. There are monthly reviews occurring to ensure/verify the use of enablers is voluntary and safe. Staff interviewed have a good understanding that the use of an enabler is a voluntary process along with approval and informed consent processes. Safety is promoted at all times for residents. Staff have access to education on de-escalation and safe and effective alternatives to restraint at orientation and at staff meetings.

## Infection prevention and control

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| 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. |

There is an appropriate and well managed infection prevention and control system. The infection prevention and control programmes is implemented across the organisation and reduces the risk of infections to staff, residents and visitors. The service’s infection prevention and control policies and procedures reflect current accepted good practice. Relevant education is provided for all staff, and where appropriate the residents.

There is a monthly surveillance programme where infection information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings.

## 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 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 100 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | New staff receive education relating to the Health and Disability Commissioner’s Code of Health and Disability Services Consumer’s Rights (the Code), as part of their orientation programme. Ongoing education on the Code is provided to all staff and this last occurred in April 2016. Staff demonstrate an understanding of the requirements of the Code, outlining how these are incorporated into their everyday practice.  Residents stated that they receive services that meet their needs, staff respect their wishes and treat residents with respect.  Respectful attitudes towards residents were observed by the audit team on the days of the audit. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The informed consent policy guides staff in relation to informed consent. All residents’ files reviewed identified that informed consent is obtained and recorded. Interviews with staff confirmed their understanding of informed consent processes. Consent is also obtained on an as required basis, such as for ‘flu’ vaccinations.  There was evidence of advance directives signed by the resident. Residents confirm they are supported to make informed choices, and their consent is obtained and respected. Family members reported they are kept informed about what is happening with their relative and consulted when treatment changes are being considered. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The advocacy service information is included in the staff orientation programme and in the ongoing staff education programme. Staff demonstrate an understanding of the advocacy service.  Residents are provided with information on the advocacy service as part of the admission process. Residents and family members confirm their awareness of the service and how to access this. Information relating to advocacy services is available throughout the facility. The information packs provided to residents and family on admission to the service contain advocacy services information. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The residents are encouraged to maintain their community interests and networks. Residents report they are supported by staff to access health care services outside of the facility. The activities programme includes regular outings and participation in community events. Community groups and entertainers visit the facility.  The service welcomes visitors, and has unrestricted visiting hours. Family members state they feel welcome when they visit. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There are appropriate systems in place to manage the complaints processes. The complaints process is readily accessible and displayed throughout the facility. The business and care manager is responsible for managing complaints. A complaints register is maintained and the complaints reviewed were managed appropriately. The complaints register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved. Residents and family members state they feel that they are listened to and issues are resolved.  Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place that ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes.  Review of the facility’s meeting minutes provides evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via meetings at the facility.  There was one complaint with the DHB in 2015 and this is resolved. There were no complaints with any other external authorities since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | During the admission process, new residents and their family are provided with a copy of the Code and information on the Nationwide Health and Disability Advocacy Service. The business and care manager advised this information is discussed with the resident and their family during the admission process. Posters and pamphlets on the Code are displayed throughout the facility.  Residents and family members interviewed were familiar with the Code and the advocacy service. Residents and family stated they would feel comfortable raising issues with any of the staff and management. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The Oceania policies and procedures are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff education on respect, dignity, and residents’ independence was conducted in 2015 and 2016, by the advocacy services. Residents and family members confirm they are treated respectfully and that the individual needs and preferences of residents are acknowledged and accommodated.  Residents are addressed by their preferred names, observed on audit days. The residents’ rooms are personalised with residents’ furniture and belongings. Staff were observed knocking on closed doors before entering, and maintaining the privacy and dignity of residents during personal cares. Discussions of a private nature are held in residents’ rooms or areas in the facility that can be used for private meetings. Residents and families confirm that residents’ privacy is respected.  The residents’ records include documentation relating to individual cultural, religious and social needs, values and beliefs that are incorporated into their individual care plans. The long term care plans include information on the residents’ abilities, and strategies to maintain/maximise their independence. The care plans are developed with input from the resident and/or their family.  Staff education and training on abuse and neglect is provided. Residents, staff, family and the general practitioner confirm that there is no evidence of abuse or neglect. Staff employment contracts and orientation information contain information relating to expected standards of behaviour/code of conduct. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has a Māori health plan that guides staff in meeting the needs of residents who identify as Māori. The business and care manager described the networks that have been established locally, if additional support is required to support any residents who identify as Māori.  The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan.  Specific cultural needs are identified in the residents’ care plans. Staff are aware of the importance of whānau in the delivery of care for the Māori residents. There were no residents who identified as Māori residing in the facility on audit days. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Interview with a chaplain confirmed residents are seen by the chaplain on admission and when spiritual service is requested. Residents and family members advised they are consulted about the resident’s individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis.  The residents’ personal needs, individual preferences, values and beliefs are identified on admission and recorded in the care plans reviewed. Residents and family are involved in the assessment and the care planning processes, confirmed in interviews with residents and family.  Staff are familiar with how translating and interpreting services can be accessed. There are residents in the service for whom English is a second language. An interview with a resident and their family member who required an interpreter (staff member) evidenced the interpreting service is effective. There are staff from the Pacific Islands and Asia who can support residents who require cultural support. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility implements the Oceania policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. The employee agreement includes standards of conduct. Residents and family members state that residents are free from any type of discrimination or exploitation.  The staff orientation programme includes information relating to discrimination and there is regular training for all staff on the topic. Staff demonstrated an understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has established professional networks to help ensure residents receive services of an appropriate standard, including specialist services at the local district health board (DHB). Policies and procedures reflect best practice and these are available to guide staff in care delivery.  There is a mandatory training programme for all staff. The managers are encouraged to complete management training. The registered nurses (RN) are supported to attend external education sessions.  Consultation is available through the organisation’s management team that includes business and care manager, clinical managers, charge nurse, RNs, the clinical and quality manager, regional manager and a dietitian. There are monthly regional management meetings with the managers interviewed confirming that they attend.  The service conducted a project focusing on surveillance of infections and areas to address minimising the infections (refer to 3.5). |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Family members state they are kept informed of any change in the resident’s condition and incidents/accidents that occur. Communication with family members is recorded in the residents’ progress notes and on family communication forms.  Management and staff are aware of their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms and residents’ clinical files.  Residents’ clinical files evidence resident and/or family participation in the assessments, care planning and evaluation of care. Residents’ meetings provide a forum for discussion.  Residents/or family members sign an admission agreement on entry to the service. The admission agreement records all information required relating to provision of the services at the facility. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lady Allum Rest Home and Village is part of the Oceania Care Company Limited group. The Oceania operations manager and the clinical and quality manager were providing support to the service on audit days.  The organisational wide mission, values and goals are documented and communicated to residents, staff and family through posters on the wall, information in booklets and in staff orientation and training.  The business and care manager reports to the Oceania support office on the facility’s progress against identified indicators, via the monthly business status report.  In November 2014 the service applied to HealthCERT for approval of reconfiguration of their certified services, by the use of existing unused rooms to provide three additional hospital/rest home (dual purpose) beds, increasing the bed numbers from 140 to 143. HealthCERT assessed the potential effect on the services as low risk and approved the use of the three additional beds. The additional bed increase has been utilised by the service.  The facility can provide care for up to 143 residents with all beds occupied at the audit. This included 39 residents requiring rest home level care and 98 residents requiring hospital level care. Six residents were identified as being under the young people with disability contract.  The business and care manager is responsible for the overall management of the service and has been in the role for eight months. The business and care manager has previous experience in aged care. There is evidence the business and care manager has completed training/education relevant to their role. The required authorities have been informed of the appointment of the business and care manager. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The management team at the facility includes one business and care manager, who is a registered nurse (RN) and two clinical managers (RNs).  There are appropriate systems in place to ensure the day-to-day operation of the service continues should the business and care manager be absent. The business and care manager and the clinical managers confirmed their responsibility and authority for their roles.  In the absence of the business and care manager, the clinical managers are delegated to the role with support from the regional operations manager and clinical and quality manager (organisational). |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Lady Allum Rest Home and Village uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice.  Oceania organisational policies and procedures are available to staff and guide service delivery. The policies and procedures are relevant to the scope and complexity of the service; reflect current accepted good practice, and reference legislative requirements. The Oceania management group reviews all policies with input from relevant personnel. New and revised policies are presented to staff to read and sign to evidence that they have read and understood the policy. Staff confirm that they are advised of updated policies and those policies and procedures provide appropriate guidance for service delivery.  The service delivery is monitored through number of clinical indicators such as: complaints; incidents and accidents; surveillance of infections; pressure injuries; falls; medication errors and implementation of an internal audit programme. Completed audits for 2015 and 2016, clinical indicators and quality improvement data is recorded on various registers and forms. Quality improvement data provides evidence that data is being collected, collated and analysed to identify trends. Where required, corrective action plans are developed, implemented and evaluated.  There is communication with all staff, residents and family through the facility’s meetings. Staff meetings evidence all aspects of quality improvement, risk management and clinical indicators are discussed. Staff report that they are kept informed of quality improvements. Copies of meeting minutes are available for review for the staff that were unable to attend the meeting.  The satisfaction survey for family and residents in 2016 shows that they are satisfied with services provided and this was confirmed by residents and family interviewed.  Health and safety policies and procedures are documented along with a hazard management programme. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Accident and incident forms are reviewed by the clinical managers and signed off when completed. Corrective action plans to address areas requiring improvement are documented, implemented and evaluated.  The clinical managers and/or the registered nurse (RN) undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate. The staff report the on call RN is called when required, in the clinical managers’ or the business and care manager’s absence.  Staff confirm they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Policy and procedures comply with essential notification reporting, for example, health and safety, human resources, infection control.  The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks and changes in key clinical managers. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Policies and procedures in relation to human resource management are available and implemented. The skills and knowledge required for each position is documented in job descriptions. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.  The organisation has a mandatory education and training programme with an annual training schedule documented. Staff are also supported to complete education via external education providers. Staff have completed training around pressure injuries in 2015 and 2016. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided. The RNs have completed interRAI assessments training and competencies. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.  An orientation/induction programme is available and new staff are required to demonstrate competency on a number of tasks, including personal cares. The staff orientation covers the essential components of the service provided. Health care assistants confirm their role in supporting and buddying new staff.  Annual competencies are required to be completed by clinical staff. There was evidence in the clinical staff files reviewed of competencies relating to: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; restraint; nebuliser; blood sugar and insulin; and assisting residents to shower. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse cover is provided seven days a week, twenty four hours a day. The staff on call roster is communicated to staff. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.  There is at least one staff member on each shift that has a current first aid certificate. Residents and family report staff provide them with adequate care. Care staff reported there are adequate staff available and that they are able to get through their work. Residents and families report there are enough staff on duty to provide adequate care. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are policies and procedures in place for privacy and confidentiality of residents’ records. Relevant resident care documentation can be accessed in a timely manner. The service retains relevant and appropriate information to identify residents and track records. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Archived records are securely stored and easily retrievable.  All components of the residents’ records reviewed include the resident’s unique identifier. The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Medication charts are kept separate from residents’ files. Resident files and medication charts are accessed by authorised personnel only.  Residents’ progress notes are completed on every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes identify the name and designation of the person making the entry. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There is a comprehensive pre-entry to service process that is effectively managed by an experienced client relations leader. The client relations leader interviewed is able to assist residents and family members in understanding the various levels of care, funding requirements and the process of needs assessment. Additional information can be sought. Attractive organisational information packs are available with all appropriate documentation for those enquiring about the service, and/or entering the service.  The information packs include useful resources and information such as, a copy of the complaints procedure, the Code of Rights and advocacy information and the Ministry of Health (MoH) Residential Long Term Care for Older People 2012 booklet. The families are contacted in a timely manner when a bed becomes available. On entry to the service the service agreement is signed and dated and full orientation of the facility is provided to the resident/family/representative. A copy of the Enduring Power of Attorney contact person is requested for the resident’s records. This is retained in the individual records reviewed. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The clinical manager and RNs interviewed stated that any risks identified prior to discharge or transfer are documented. A transfer form is used and the ‘yellow bag system’, a DHB initiative, is utilised. The RN ensures open disclosure between services and family/whānau/representatives occurs. This includes residents for either discharge and/or transfer to another facility or to the DHB.  If there are any specific requests or concerns that the resident and/or family want discussed, these are noted on the transfer form. The discharge summary and copy of the interRAI assessment and person centred care plan is provided and covers all personal cares and needs of the resident and any interventions required. Any identified risks, alerts, medication allergies/sensitivities, issues or concerns are highlighted. If a transfer occurs a copy of the medication record, the resident information summary and any advance directive also accompany the resident if they are transferred to hospital. Family are kept well informed throughout the process. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication policies are accessible to guide staff, as required. The sighted policies meet legislative and best practice guidelines. All RNs are responsible for medication management in the respective units in which they work. The two clinical managers oversee this aspect of service delivery. All have completed medication competencies.  Medicines are received from the contracted pharmacy in pre-packed delivery system. The medications are checked for accuracy by the RNs. The medications are stored in the medication room in each unit and a medication trolley is available. A signature specimen list is available to verify signatures if required. There are clear processes for any medication incidents/events.  A safe system for medicine management was observed on the day of the audit in Arohanui Unit (hospital unit). The GP interviewed stated that there have been no significant medication errors in which the GP has been involved. The RNs can contact the GPs with any queries or points of clarification, as needed. Controlled drugs are managed appropriately and balances of stock medications are correct.  The medication records reviewed have been regularly reviewed in the appropriate time frames required. All medicines are prescribed individually on the records reviewed. Photographic identification is evident on all the medication records reviewed. The medication signing records are generated from the pharmacy and as each medication is administered it is signed off by the RNs respectfully. A system is in place for medication returns to the pharmacy. These are recorded and monitored. PRN medication is also monitored by the RNs and this is discussed with the GP, as required. Alert stickers are used in the records for duplicate names, allergies, diabetic, controlled drugs and others. The contracted pharmacy completes six monthly audits. Standing orders are reviewed annually by the GPs.  No residents are self-administering medications. A policy exists should this situation arise. The GP has to authorise a resident to be able to self-administer medicines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is managed by a contracted service provider. The menus are developed by the food safety manager who has worked at this site for five and half years and is a qualified chef. The Chef is responsible for all food procurement, ordering, transportation, monitoring and purchasing of all foodstuffs. This is the only Oceania facility with a contracted service provider. A food service plan is developed and implemented. Cleaning schedules for staff to complete in each of the six service areas and including the main kitchen site. Food temperature and fridge/freezer monitoring is maintained and records are available. A bain marie system was observed at lunchtime. Each unit receives the main meals in this way.  The RNs complete a nutritional profile for each resident upon entry to service and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for appropriately. Residents in each of the units have a menu inclusive of choices available on a daily basis. Special events are catered for and the organisation dietitian can be contacted as needed on a referral basis.  The chef is well informed about food handling and practices to meet legislative requirements. The kitchen staff have completed food safety training NZQA167 and the chef NZQA168. The service was externally audited recently. There are no internal food safety audits completed. Families can stay for a meal if they wish. Special functions are catered for by the food safety manager.  Annual service satisfaction surveys completed by residents/family included the food service. The families and residents interviewed reported satisfaction with the meal service. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service provides rest home rooms, care suites, hospital rooms and nursing assistance is provided twenty four hours, seven days a week. Declining a referral does not occur often due to the services offered, however, there is no higher level dementia service available or mental health services. If a resident’s condition changes requiring more appropriate specialised care this is arranged and the reason is documented in the resident register maintained. Family are assisted in every way to find an appropriate service provider to meet the needs of the resident. The client relations leader assists with this process during the pre-entry process and with staff if a current resident’s needs change and other options are required. The registered nurse in this situation is required to complete an interRAI assessment if a transfer is planned. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The interRAI assessments are available on line. Any additional assessments, as required, are completed by the registered nurses, such as risk assessments, pain assessments and cultural assessments and others depending on identified needs for the individual resident.  Results of the assessments are discussed with the resident, staff and families and included in the care plan as needs with appropriate interventions in place.  Residents, staff and families interviewed reported appropriate care is provided that meets the identified support needs and preferences. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The residents’ records reviewed have person centred care plans. The strategies minimising falls risk on assessment and use of techniques that are effective for the resident and are evidenced in the records reviewed. The health care assistants interviewed demonstrated knowledge on the management of falls risks for residents.  The care plans and activities plans sighted in the residents’ records reviewed identified the resident’s individual diversional, motivational and recreational requirements, with documented evidence of how these are managed. The residents’ records demonstrated integration, continuity of service delivery and team work is promoted. The handover observed included updates of all residents in the unit.  The families interviewed reported a high level of satisfaction with the quality of care provided at this service. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Support and care is individualised and focused on achieving desired outcomes/goals set. The registered nurses (RN) and healthcare assistants 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 care and services provided.  Short term care plans are developed as necessary for any event that is not part of the long term care plan, such as unexplained weight loss or wound care/pressure injury management. The RNs ensure the GP is kept well informed of progress. This was confirmed by the GP interviewed.  The service has adequate and up-to-date wound and continence products to meet the needs of the residents. The care plans reviewed demonstrated interventions that are consistent with the resident’s assessed needs being able to be effectively met. Observations on the day of the audit indicated residents’ are receiving care that is consistent with meeting their assessed needs. The RNs interviewed reported care plan interventions are regularly reviewed and are current. The RNs are allocated residents to be responsible for from admission and in the longer term. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme ensures resident’s individual motivational, recreational and cultural needs are recognised. Each resident is assessed by the diversional therapist on admission. The residents’ have the opportunity to maintain interests, choices and activities in a continuing care environment. Each of the six units has their own activities coordinator. The team leaders sign off the monthly plan and the activities weekly plan for each unit. A copy of the year plan was reviewed. There is one qualified diversional therapist and all other staff are working on papers towards attaining this qualification. There is an occupation therapist who is available and attends the weekly meetings.  A new initiative and continuous improvement project is the memory lane booklets which provide a profile and life journey for each resident. The information is shared with staff at handover and a copy is retained in the resident’s individual record. The diversional therapist and coordinator interviewed is aware that resident participation is voluntary and this is respected by staff. A recreation attendance list is maintained.  Residents are encouraged to maintain links with family and the community at every opportunity. There are six outing arranged each week and each of the six units have specific days. There is a van outing register and consent is obtained. Special days are celebrated. A photo board is used in most of the units displaying activities enjoyed by residents.  There is a chaplain available for this service and a church service is held weekly. The chapel is part of a multipurpose lounge and is utilised for many functions held for residents and families. The chaplain was interviewed. Communion can be arranged to meet the needs of residents.  At the time of the audit residents were visibly enjoying activities in the different units and residents interviewed reported that they enjoy the variety of planned activities arranged. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluation of the person centred care plans occurs six monthly, or earlier as applicable. Evaluations are focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting set goals. If the 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/representative. Short term care plans are developed and implemented as needed. A folder was sighted in each of the six units visited.  The healthcare assistants interviewed demonstrated good knowledge of short term care plans and reported that these are followed and information is shared in the handover process between shifts. Progress is also discussed at the multi-disciplinary reviews six monthly.  Families reported that they are consulted when staff have any concerns or when there are changes to the resident’s condition. This is documented on the family communication record in the records reviewed. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are provided with options if required to access other health and disability services. There are three general practitioners (GP) contracted to the facility and the GPs visits the service regularly on allocated days. An after-hours service is provided. The GP interviewed explained the referral process. Examples of referrals were seen in the individual resident records reviewed. Copies of all referrals are retained in the records. Specialist medical and surgical referrals are arranged as needed. There is a process for transferring residents, if and when required. The DHB referral system is followed through and is a guide for the GP and staff after hours, as needed.  The clinical manager and RNs interviewed reported that referral services respond to referrals sent in a timely manner. The DHB acknowledges the date a referral is received and actioned. Records of the processes maintained was confirmed in the residents’ records reviewed, which includes referrals and consultations to orthopaedic specialists, radiology services, geriatricians/nurse practitioners, dietitians and other health professionals, as required. The GP interviewed reported that appropriate referrals to other health and disability services are well managed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes are in place for the management of waste and hazardous substances and these are implemented. Material safety data sheets provided by the chemical representative are available and accessible for staff. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.  Observations evidence that: hazardous substances are correctly labelled; safely stored; protective clothing and equipment is available; and staff use the protective clothing and equipment. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed that expires on 15 March 2017. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose.  There is a preventative and reactive maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of biomedical equipment is current. Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use any equipment.  The external areas are maintained and appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. Residents confirm they are able to move freely around the facility and outdoors and that the accommodation meets their needs.  Reconfiguration of the certified services, by the use of existing unused rooms to provide additional three hospital/rest home (dual purpose) beds has occurred. The additional beds did not require any additional building configuration. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of accessible communal showers, toilets and hand basins for residents. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are maintained at a safe temperature.  Communal toilets and showers have a system that indicates if it they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All bedrooms provide single accommodation, except for one married couple who share a room. All residents’ rooms are personalised to varying degrees. Bedrooms are large enough to provide personal space for residents, and allow staff and equipment to move around safely. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Adequate access is provided to the lounges and the dining rooms. Residents were observed moving freely within these areas. Residents confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry policies and procedures are documented and implemented.  Linen service is conducted at another Oceania facility. There are processes in place for collection, transportation and delivery of linen and residents’ personal clothing. The effectiveness of the cleaning and laundry services is audited via the internal audit programme. The cleaner described the cleaning processes.  There are safe and secure storage areas and staff have appropriate and adequate access to these areas, as required. Chemicals are labelled and stored safely within these areas. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility.  Residents and families stated they were satisfied with the cleaning service. Business and care manager stated there are areas requiring improvement around the laundry service and corrective actions are in place. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification are available.  A New Zealand Fire Service letter approving the fire evacuation scheme dated 12 April 2007 was sighted. Trial evacuations are held six monthly. Emergency and security management education is provided at orientation and at the in-service education programme. Information in relation to emergency and security situations is readily available/displayed for staff and residents. The emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting.  There is a call bell system in place that is used by the residents, family and staff members to summon assistance, when required. Call bells are available in all resident areas. Call bells are monitored by the maintenance staff monthly. Residents confirmed they have a call bell system in place, which is accessible and staff respond to it in a timely manner.  The reconfiguration of the services, by the use of existing unused rooms to provide an additional three hospital/rest home (dual purpose) beds did not require new fire evacuation scheme or additional emergency or security services. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.  The business and care manager stated there are no residents at the facility that smoke. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Infection control (IC) is promoted at every opportunity. The service has a managed environment which minimises the risk of infection for residents, staff and visitors. The IC programme is led by the clinical manager/infection control nurse (ICN). The infection prevention and control programme is reviewed annually. Goals are set at the beginning of each year and the IC plan for 2016-2017 was available. The ICN monitors all infections, uses standardised definitions to identify infections appropriately, and carries out surveillance monitoring of organisms, related to antibiotic use. Monthly records sighted are maintained. Infection prevention and control is presented at each staff meeting. Minutes are available and were reviewed.  The ICN interviewed and the registered nurses (RN) when interviewed fully supported the programme and have a good understanding of the early detection of suspected infections. Senior staff are supported by the healthcare assistants who are informed and report any signs and symptoms or concerns that residents may display in the day to day interactions with the residents they are providing care to. The shift handovers observed are a forum for reporting infections. Short term care plans are used, for example, for wound care and other infections. There is an infection record sheet which is maintained by the RN in each of the six units and this is then given to the ICN.  A process is identified in policy for the prevention of exposing others to infection. Staff interviewed knew when not to come to work and when to return. Signage is used in the facility, as required. Sanitising hand gel is evident throughout the facility and there are adequate hand washing facilities for staff, visitors and residents.  The programme reviewed is appropriate for this large residential aged care setting and the services provided. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICN has been in this role for three years. The ICN reports to management monthly. Any trends or issues identified are reported to staff. External specialist advice is available from the contracted GPs, the laboratory microbiologist and the infection prevention and control nurse specialists at DHB can be contacted as required. The GP interviewed is informed of obligations and reporting systems, if needed, for notifiable infections outbreaks of disease or illness. There have been no outbreaks of infection since the last audit. Guidelines, policies and procedures are in place for staff to follow should an incident arise. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The objectives/goals of the IC programme are documented including IC education, hand washing competency annually to be re-instigated, committee members committing to on-going surveillance and the facility to follow the principles of antibiotic stewardship in order to minimise multi-resistant organisms (MROs). The policies and procedures are practical, safe and appropriate for this aged residential care service.  Staff interviewed stated they have access to the policies, procedures and guidelines, as required. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | IC education is included in the orientation programme for all staff and is part of the ongoing IC annual plan for 2016-2017. Infection prevention and control education is provided by the clinical managers, ICN and the RNs in each unit. The staff interviewed stated that education is also provided by external trainers, for example, product representatives for the cleaning, kitchen and laundry services is completed by all staff, as required. An IC questionnaire is completed annually by staff.  The RNs can attend additional education through the DHB infection prevention and control nurse specialists. The RNs and health care assistants demonstrated knowledge of infection prevention and control and reporting systems. Staff verified information is fed back if there are any significant issues or trends are identified.  Resident education is conducted, as required. Hand hygiene is encouraged by all staff and management at every opportunity. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Policy identifies that surveillance data is used to identify trends and corrective planning is put in place, as appropriate. The organisation has a system in place to ensure infection prevention and control is managed by a qualified ICN.  Clear definitions and types of infections are documented to guide staff. Information is collated on a monthly basis from each of the six units. Information gathered is analysed monthly and linked to the quality and risk management programme. There is an IC report that is issued by the laboratory service which outlines all infections, types of infections, and resistance/sensitivities and suggested antibiotics to be prescribed for the specific infections identified. The ICN enters these results into the organisations clinical indicators/outcomes and this is forwarded to head office on a monthly basis.  There is a continuous improvement for surveillance for infections identified at this audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint minimisation and safe practice handbook and policies reviewed comply with the standard and there are clear definitions of restraint and/or enabler use. The use of restraint is actively minimised. Currently three residents are using a form of restraint, one a bedrail and two are using lap belts. Three enablers are in use. Separate restraint and enabler registers are maintained.  Staff interviewed had a good understanding that the use of enablers was a voluntary process along with approval and informed consent processes. Signed consent forms are on the records sighted. The resident person centred care plans detail the use of enablers. Monthly resident enabler reviews verify that enablers are being used appropriately and safely.  Staff have access to education on safe and effective alternatives to restraint at orientation and this is ongoing. Managing challenging behaviour is included in the education programme. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint minimisation practice handbook and policies March 2015-2017 were reviewed. All relevant legislation and requirements for restraint inclusive of definitions and safe and appropriate guidelines for management of the use of restraint is documented. The processes implemented reflect the safe use of restraint and enablers.  Three of the six units are completely restraint free. Approval is made in conjunction with the registered nurse on the unit, the GP and the restraint coordinator.  The restraint coordinator interviewed is a qualified occupational therapist and has a job description for this role. There is a flow chart available which clearly outlines the processes for restraint/enabler approval. A restraint assessment authorisation and plan is completed by the registered nurse at the time. Resident input is sought as applicable. The form outlines the conditions for the use of the restraint/enabler and verifies this has been explained to the resident/family/whānau.  For all residents for whom restraint/enablers are being used, evaluation is undertaken to gauge the effectiveness or otherwise of restraint/enabler as an appropriate safe intervention. The resident/family/ whānau are involved in the evaluation process. The evaluations are completed three monthly and are documented and signed off by the restraint coordinator. The restraint coordinator stated that reviews would be undertaken sooner if restraint is no longer required or if it does not appear to be keeping the resident safe as it is intended to do. The resident and family/whānau, as appropriate, would be fully informed of this decision.  Interviews with staff confirm their understanding and use of the restraint and the person centred care plan. Education is provided to all staff in the form of a workshop and education covers alternatives to restraint/enabler use and management of restraint minimisation and safe practice. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service undertakes a comprehensive assessment process prior to restraint approval. The signed forms are retained in the individual resident records. These are well documented and the restraint/enabler intervention is documented in the person centred care plans. Any risks identified relating to the use of restraint would be flagged. Cultural safety is respected. Possible alternative de-escalation strategies are documented.  Registered nurses have a good understanding of the assessment process and appreciate the input from the healthcare assistants in how to best manage each resident. Any advanced directives are kept in the individual resident’s records. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The restraint coordinator ensures all policies and procedures are continually monitored by the restraint approval group at senior management level. The organisation quality team has reviewed the restraint minimisation and safe practice folder. All restraint is approved prior to use following appropriate assessment processes being completed and reviewed by the approval group.  Monitoring is determined by the identified risk of restraint/enabler use. Staff ensure this occurs and monitoring is recorded accurately. Restraint is only used as a last resort. Safety is paramount.  The restraint register establishes sufficient information to provide an auditable record of restraint use. It identifies that enabler/restraint is approved for each resident and that the use is reviewed and evaluated three monthly by the restraint coordinator. The GP interviewed is well informed of all processes and documentation required. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluations occur three monthly and are discussed at the multi-disciplinary reviews for each respective resident using a form of restraint/enabler. Family/whānau or a nominated representative are involved with the process, with consent from the resident. The evaluation forms reviewed evidence that policies and procedures are followed. The evaluation forms are visible in the individual records reviewed. All are completed and signed off appropriately. If any changes have occurred the resident/family/whānau would be fully informed and any relevant changes made to the individual person centred care plan. Advocacy and support can be accessed at any time for residents/family/whānau. Residents have a right to have a support person present during the evaluation process and this is implemented and encouraged by the service. Observations and monitoring expectations are met as forms are retained in the records reviewed. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service is able to demonstrate through the documentation sighted that three monthly monitoring and annual quality reviews are conducted relating to the use of restraint/enablers. Equipment and resources are available such as hoists for all areas of service provision. Restraint team meetings are held monthly. Senior staff and registered nurses attend. The clinical leaders discuss each resident and ensure their needs are being met. The restraint coordinator reports to management and to head office on a monthly basis. Quality review findings and any recommendations are used to improve service provision and resident safety. The restraint minimisation and safe practice handbook and policies were updated between March 2015 – March 2017 and are available to guide staff.  The restraint minimisation and safe practice education provided for all staff is well managed and staff attend workshops on a regular basis, as documented in the education calendar. Records are maintained by the restraint coordinator. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
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| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | The two clinical managers oversee the clinical service at the facility. RNs complete monthly infection logs of any infections identified for individual residents. The ICN and the committee observed that there were four to six residents admitted with known infections identified and at the same time with numerous susceptible organisms and two residents had to be readmitted to the DHB for intravenous antibiotic therapy.  A quality improvement project was developed and implemented by the clinical manager/ICN with support of the three GPs contracted to this service, the registrar of infectious diseases at the DHB and the DHB community pharmacist. The antibiotic stewardship programme was implemented after all staff were trained. No antibiotics were prescribed for residents until all results were available. Targeted antibiotics (narrow spectrum antibiotics), not broad spectrum antibiotics are now being used and the residents concerned are displaying minimal resistance/sensitivities to treatment when antibiotics are required. | The service can demonstrate a review process including analysis of the findings, evidence of actions taken based on the findings, and improvements to service provision and residents safety or satisfaction as a result of the review process. The service is managing infection prevention and control to ensure the risk is minimised and this is evident in the summary results sighted. IC incidences are at the lowest for this service due to strategies in place and the vigilance of all staff in recognising early signs and symptoms of possible infection and diagnosis and newly implemented treatment options. The infection prevention and control programme is closely linked to the quality improvement and risk management system. The antibiotic stewardship programme project is ongoing and is discussed regularly at the infection prevention and control meetings, staff communication meetings and DHB IC meetings. Dialogue continues with the DHB registrar and the clinical pharmacist for aged care in the community. |

End of the report.