

# Arbor House Trust - Arbor House Rest Home

---

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Arbor House Trust
<b>Premises audited:</b>	Arbor House Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 13 June 2016    End date: 13 June 2016
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	23

# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Arbor House rest home and hospital is a not-for-profit organisation that is owned and operated by a Community Trust Board. The Board employs a nurse manager who is responsible for the daily operations of the service. A registered nursing team and stable workforce support her. The service provides rest home and hospital level of care for up to 26 residents. On the day of the audit, there were 23 residents.

The residents and relatives interviewed spoke positively about the care and services provided at Arbor House.

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

This certification audit identified areas for improvement around meeting minutes and corrective actions, completion of accident/incident forms, performance appraisals, progress notes, initial assessments, care plans, interventions, aspects of medicine management, hot water temperature monitoring, review of infection control programme and restraint job description and assessments.

## 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.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Arbor House rest home provides care in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about the Code and services is easily accessible to residents and families. Family/friends are able to visit at any time. Residents and family interviewed praised the support and care provided. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------

Arbor House rest home has a documented quality and risk management system. The service has implemented policies and procedures from a recognised aged care consultant. Quality data is collated for accident/incidents, infection control, internal audits, concerns, complaints and surveys. The service has a risk management plan 2015 – 2017, which includes clinical risks as well as business risks. There are human resources policies to support recruitment, selection, orientation and training and development of

all staff. The service has an orientation programme that provides new staff with relevant information for safe work practice. A documented in-service programme for education covers compulsory training requirements. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-----------------------------------------------------------------------------------------------------------------------------------

There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident files included notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for administration of medicines and complete annual education and medication competencies. The service has implemented an electronic medication system.

A recreational officer coordinates the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each consumer group. Residents and families report satisfaction with the activities programme.

All meals are prepared and cooked on-site. Residents' food preferences and dietary requirements are identified at admission and accommodated. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines.

## Safe and appropriate environment

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

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with access to ensuites or communal facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place, to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------

A restraint minimisation and safe practice policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There is a restraint register and an enabler's register. There are four residents utilising restraint and three residents with an enabler. There is an annual restraint-approval group meeting.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There is a suite of infection control policies and guidelines to support practice. Information is obtained through surveillance to determine infection control activities and education needs within the facility.

## 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	38	0	8	4	0	0
<b>Criteria</b>	0	88	0	9	4	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with nine staff (one nurse manager, two registered nurses (RN), four caregivers, one cook and one recreational officer) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Five residents (four rest home and one hospital level) and relatives (three hospital level) interviewed confirmed that the services being provided are in line with the Code. Observation during the audit confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in the five resident files sampled (two rest home and three hospital including one younger person under long-term chronic health contract - LTCHC). Advance directives if known were on the resident files. Resuscitation plans were sighted in all files and were signed appropriately. Copies of EPOA were on files as required.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand</p>

		<p>informed consent processes and that appropriate information had been provided.</p> <p>All residents' files sampled had signed admission agreements on file.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and advocacy pamphlets on entry. Resident advocates are identified on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Caregivers interviewed are aware of the resident's right to advocacy services and how to access the information.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy and family and friends are encouraged to visit and are not restricted to visiting times. All residents interviewed confirmed that relatives and friends are able to visit at any time. Visitors were seen visiting the home. Residents and relatives verified that they are supported and encouraged to remain involved in the community. The service has a van for group outings. Community groups visit the home as part of the activities programme.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The procedure for complaints is provided to residents and relatives at entry to the service. The nurse manager maintains a record of all complaints, both verbal and written by using a complaints book (register). There was one complaint made in 2015 and one in 2016 (year to date). Resolution and sign-off of the complaints were completed within the required timeframes. Residents and family members interviewed advised that they are aware of the complaints procedure.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code of Rights. Regular resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed. Advocacy and Code of Rights information is included in the information pack and are available at reception.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Resident files include cultural and spiritual values. Residents and</p>

<p>Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>relatives interviewed reported that residents are able to choose to engage in activities and access community resources. The nurse manager is the privacy officer and has an open door policy.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There is a Māori health plan and ethnicity awareness policy and procedure. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau. The service has established links with local Māori. Staff interviewed confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff training around cultural safety last occurred in March 2016.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognises and responds to values, beliefs and cultural differences. Residents and family interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Residents interviewed confirm that staff take into account their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with care staff could describe how they build a supportive relationship with each resident. Residents interviewed stated that they are treated fairly and with respect.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The nurse manager and staff are committed to providing services of a high standard, based on the service philosophy of care. All residents and families interviewed spoke positively about the care and support provided. Staff meetings and residents' meetings are conducted. Staff have a sound understanding of principles of aged care and state that they feel supported by management. Care staff complete competencies relevant to their practice. Staffing policies include pre-employment and the</p>

		requirement to attend orientation and ongoing in-service training. The education coordinator/RN is responsible for coordinating the internal audit programme.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were welcomed on entry and given time and explanation about services and procedures. Management promote an open door policy. Relatives are aware of the open door policy and confirm on interview that the staff and management are approachable and available. Resident/relative meetings encourage open discussion around the services provided (meeting minutes sighted). Relatives interviewed stated they were kept informed of any resident changes to health (link 1.2.4.3.). Residents and family are informed prior to entry, of the scope of services and any items they have to pay for that is not covered by the agreement. The nurse manager stated that they could access interpreter services if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Arbor House rest home provides rest home and hospital level care across 26 beds. There are 10 rest home beds, 10 hospital beds and 6 dual-purpose beds. On the day of audit, there were 24 residents (nine rest home and 14 hospital level). There was one resident on respite and one younger persons under LTCHC contract (both hospital level). All other residents were under the ARCC. A nurse manager who has been in this role since May 2014 manages the service. She has a background in emergency nursing and has non-clinical management experience in a district health board. She is supported by an education coordinator/RN who has been in the role for six years and an office manager who has been in the position for one year. The nurse manager reports monthly to the community trust board (confirmed by the two board members interviewed).</p> <p>Arbor House rest home is owned and operated by a Community Trust. This 'not for profit' trust is led by a board of directors. There is a documented mission statement and philosophy. The current quality improvement and risk management plans have been implemented with progress toward goals and achievement documented. There is a business plan 2016-2017 with long-term strategies and short-term goals. The goals for 2016 and direction of the service are well documented.</p> <p>The nurse manager has maintained at least eight hours annually of professional development activities related to managing a rest home/hospital.</p>
Standard 1.2.2: Service Management The organisation ensures the	FA	The senior RN provides cover during a temporary absence of the nurse manager. Two members of the board help with overseeing the facility.

<p>day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>Arbor House rest home and hospital has an established quality and risk management system that supports the provision of care. The service has implemented policies and procedures from a recognised aged care consultant. The plan includes clinical risks as well as business risks. Quality data is collected and evaluated and used for quality improvement. Arbor House has a risk management plan 2015–2017. There is a documented and implemented audit schedule and audit outcomes are reported to the board on a monthly basis with action plans. The report to the board also includes incidents and accidents, infection control and complaints.</p> <p>A review of audits and meetings evidences that internal audit action plans are not consistently signed off when completed. There is a document control system. All policies include the date the policy was last reviewed and a review date, and manager’s signature noting that policies have been reviewed.</p> <p>The health and safety officer interviewed confirmed her understanding of health and safety processes. She has completed the level two external health and safety training. The health and safety programme monitors hazards, staff incidents and maintained the hazard register. The hazard register is current. Health and safety is discussed at the monthly staff and quality/RN meetings. An independent advocate holds resident/relative meetings every four months.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents, sensor mats for relevant residents and the identification of interventions on a case by case basis to minimise future falls. An annual residents/relatives survey was completed in May 2016.</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</p>	<p>PA Moderate</p>	<p>The service collects incident and accident data and reports aggregated figures monthly to the board, and monthly to the staff and quality/RN meetings. Staff interviewed confirmed that incidents and accidents were discussed with them. Since the previous audit, the nurse manager analyses data including place and time of incidents, and informs staff for appropriate interventions. Seven of 12 incident forms reviewed identified assessment and follow-up by a registered nurse. Not all incident forms identified that family were informed of the incident. The manager was aware of when and who to report essential notification to. There has been no issues that need to be reported.</p>

of choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Arbor House has 36 staff, which includes eight RNs (including the nurse manager). There are human resources policies to support recruitment, selection, orientation and training and development of all staff. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Six staff files were reviewed including one nurse manager, one office manager, one RN, one caregiver, one cook and one recreational therapist. Four of six staff files reviewed evidenced that staff annual performance appraisals have not been completed.</p> <p>An orientation programme includes organisational structure and policies and general information for staff. Staff are orientated to their area of work and complete competencies relevant to their role. Staff interviewed stated that new staff are adequately orientated to the service. A documented in-service programme for education covers compulsory training requirements. An education schedule for 2016 was in place. Three RNs (including the nurse manager) have completed InterRAI training. A copy of practising certificates for registered professionals has been maintained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The RN on duty completes staff duty allocation and resident's acuity dictates the staff levels and allocation. There is at least one RN on duty 24 hours a day, seven days a week. The nurse manager stated that she works on the floor at least once a week and covers RN absence if required. There is dedicated laundry and cleaning staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Records overall within resident files were signed; however progress notes reviewed did not have recorded time of entry. Policies outline security of records. Files are kept in a locked cupboard in the nurse's station.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is</p>	FA	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs are provided for families and residents prior to or on admission. The service has a comprehensive information folder for residents/families/whānau at entry. Five admission</p>

<p>facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses are responsible for the administration of medications, have completed annual competencies and have attended annual medication education. The services use an electronic medication system. There is documented evidence of medication reconciliation on delivery of medications.</p> <p>Standing orders are used however, the format does not meet legislative requirements for standing orders. There is one resident self-medicating with a medication competency that has not been reviewed three monthly. All medications were stored correctly and within the expiry dates. The medication fridge is monitored weekly.</p> <p>Ten medication charts and signing sheets were reviewed on the electronic medication system. All charts had photo identification and allergy status identified. Prescribing for 'as required' medications did not meet legislative requirements. Oxygen was not charted for one resident.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals and baking at Arbor House are prepared and cooked on site by qualified cooks. A weekend cook and an afternoon kitchenhand supports the Monday to Friday cook. A dietitian has reviewed the four-weekly seasonal menu. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements, cultural and religious food preferences are met. Additional or modified foods and diabetic desserts are provided by the service.</p> <p>Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Chemicals are stored safely. A cleaning schedule is maintained.</p> <p>Resident meetings and surveys provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food</p>

		<p>choices were offered for dislikes.</p> <p>Food services staff have completed training in food safety and hygiene and chemical safety.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RN completes an initial assessment on admission (link 1.3.3.3) including risk assessment tools. An InterRAI assessment is undertaken within 21 days of admission and six monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others (link 1.3.5.2). InterRAI assessments, assessment notes and summary were in place for all resident files sampled.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Resident care plans reviewed had been developed within three weeks of admission. Not all resident supports and needs were included in the care plans for all resident's files reviewed. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian, community mental health team and palliative care team.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs</p>	PA Low	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file (reviewed) on the relative contact form.</p>

<p>and desired outcomes.</p>		<p>Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for six residents (two rest home and four hospital) with minor wounds. There were no pressure injuries on the day of audit. The service has access to wound nurse specialists.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified</p> <p>Residents are weighed monthly or more frequently if weight is of concern. A shortfall was identified around interventions for weight management. Monitoring occurs for observations, neurological observations signs, blood sugar levels, pain and challenging behaviour.</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 service employs a recreation officer who has commenced diversional therapy (DT) training and has completed dementia unit standards. The recreational officer attends two monthly regional DT meetings that include education and guest speakers. The recreational officer works 35 hours per week from Monday to Friday and has an activity assistant for nine hours per week. The rest home/hospital integrated programme provides a variety of activities that meet the individual and group physical and cognitive abilities of the resident groups. One on one activity such as individual walks and reading occur for residents who are unable or choose not to be involved in group activities. The resident advocate and families are involved in the activity programme. There are regular entertainers and community visitors such as Tai Chi instructor, church groups, inter-home visits, pre-school children, RSA visits and Parkinson society visits for exercise groups. Residents are encouraged to maintain community links, with visits and outings into the community and attending regular social events.</p> <p>An activity assessment and plan is completed on admission in consultation with the resident/family (as appropriate). Activity plans in all files were reviewed six monthly.</p> <p>Families are invited to the resident meetings taken by the resident advocate. The service also receives feedback and suggestions for the programme through surveys and meetings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The RN evaluated all initial assessments within three weeks of admission. Long-term care plans (reviewed) have been reviewed against the resident goals at least six monthly or earlier for any health changes. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. The resident/relative had been involved in the review of care plans.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety datasheets are readily accessible for staff. Chemicals are stored in an external locked shed. Chemicals are stored safely throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit.</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>	<p>PA Low</p>	<p>The building has a current building warrant of fitness that expires 30 June 2016.</p> <p>The nurse manager oversees the maintenance programme. A maintenance person and groundsman are employed. There is a reactive and planned maintenance programme in place, however hot water monitoring has not been completed monthly.</p> <p>Essential contractors are available 24 hours. Electrical testing has been completed annually. An external contractor completes annual calibration and functional checks of medical equipment. Environmental improvements include exterior painting of the building and roof, repainting of the kitchen and upgrading of a toilet/shower area. There is a bed replacement programme in place for electric beds with pressure injury rating mattresses</p> <p>The facility has wide corridors with rails and sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade is provided.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are adequate numbers of communal bathrooms/toilets for residents in single rooms without ensuite facilities. Communal toilet facilities have a system that indicates if it is engaged or vacant. Residents interviewed state their privacy is respected when staff are attending to their personal hygiene needs.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the facility include a main lounge, day lounge and dining area. Seating and space is arranged to allow both individual and group activities to occur. All communal areas are easily accessible for residents using mobility aids or requiring staff assistance to the communal areas. The facility is light, odour free and with outlooks out to the grounds. There is a designated resident smoking area.</p> <p>All furniture is safe and suitable for the residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry and cleaning services. There are dedicated laundry and cleaning staff. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.</p> <p>Current safety material datasheets about products are readily available. Cleaning trolleys are well equipped and locked away when not in use.</p>
<p>Standard 1.4.7: Essential,</p>	FA	<p>There is an approved evacuation scheme signed off by the New Zealand Fire Service on 10 June 2013.</p>

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of the orientation for new staff.</p> <p>Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents were provided with adequate natural light, safe ventilation and heating. Each room has a panel heater that can be individually controlled.</p> <p>There are sufficient doors and external opening windows for ventilation. All bedrooms have good-sized external opening windows that are designed and installed to promote ventilation and to be secured as needed.</p> <p>The residents and family interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	PA Low	<p>The RN is the infection control coordinator supported by an infection control representative (housekeeper) to oversee infection control for the facility. The infection control coordinator has a defined job description that outlines the responsibility of the role. Infection events are collated monthly and reported to the combined staff/quality meetings and board meetings.</p> <p>There is no documented annual review of the infection control programme.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	FA	<p>The RN infection control coordinator has attended external education at the DHB within the last six months. The RN study day for the older person's health included wound care and outbreak management training.</p> <p>The infection control coordinator has access to GPs, local laboratory, the infection control nurse</p>

infection control programme and meet the needs of the organisation.		specialist and public health departments at the local DHB for advice.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by the DHB infection control nurse specialist and last reviewed April 2016.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule.</p> <p>Resident education is expected to occur as part of providing daily cares as appropriate.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. An infection control register is maintained and short-term care plans are completed for infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place, appropriate to the complexity of service provided. Infection control data is discussed at both the staff/quality meetings. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule (link 1.2.3.6). Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks.</p>
Standard 2.1.1: Restraint	FA	Arbor House has policies and procedures on restraint minimisation and safe practice. The education

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>coordinator/RN is the restraint coordinator. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. There is a restraint and enabler register. There were three residents with enablers (bedrails) and four residents with restraints in use on the day of audit (four bedrails and one lap belt). Interviews with RNs confirmed that the use of enablers is voluntary.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	PA Low	<p>The restraint coordinator is a RN and understands the role and her accountabilities. There is no job description in place for the restraint coordinator. The consent for restraint included the restraint coordinator, registered nurses, resident or family/whānau representative and medical practitioner.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	PA Moderate	<p>The four residents who require restraint have signed consents, however assessments have not been completed, including identification of risks associated with the use of restraint. Not all restraint care plans reviewed identified interventions to manage the risks or the restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified. The GP and restraint coordinator approve the use of restraint in discussion with the resident (as appropriate) and the relative who signs the consent form. Restraint monitoring forms were reviewed for the four residents on restraint, which evidence two hourly monitoring including the provision of care during restraint episodes.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every three months. Three monthly evaluations had been completed with the resident, family/whānau and restraint coordinator. Evaluation timeframes are determined by policy and risk levels.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint usage across the facility is monitored monthly. There is an annual restraint approval group meeting to review all restraint use.</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------	-----------	---------------------------------------------------------------------------------------------------------------------------------------------------

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	Arbor House rest home and hospital has a series of meetings scheduled and in place. These include monthly staff and quality/RN meetings. All meetings have agenda items, which include reporting of quality information.	i) 13 out of 28 internal audits reviewed, did not have corrective actions signed off when completed; ii) Staff and quality/RN meeting minutes lack documented evidence around discussions and required corrective actions; iii) Corrective actions have not been developed for all identified issues.	i) Ensure that all action plans are signed off when completed; ii)) Ensure that staff and quality/RN meeting minutes include discussions around quality data or any other issues and that the follow-up process is identified and completed; iii) Ensure that corrective actions are developed and completed for all

				identified issues.  90 days
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>The service collects incident and accident data and reports aggregated figures monthly to the board and monthly to the staff and quality/RN meetings. Five of 12 incident forms did not identify RN follow up. Five of 12 incident forms did not identify family were informed.</p>	<p>Of the twelve resident related incident forms reviewed, documentation following incidents evidenced the following: Five incidents did not have documented RN assessment or sign off. Five incidents did not document if next of kin had been informed.</p>	<p>Ensure that there is documented RN assessment and sign-off of incident forms, including documented evidence of family notification.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>A documented in-service programme for education covers compulsory training requirements. However, staff have not completed pressure injury prevention. An education schedule for 2016 was in place. Three RNs (including the nurse manager) have completed InterRAI training. A copy of practising certificates for registered professionals has been maintained. Two of six staff files reviewed had an up-to-date performance appraisal.</p>	<p>(i) Four staff files out of six reviewed did not have up-to-date annual staff performance appraisal; (ii) The staff have not completed pressure injury prevention training in the last two years.</p>	<p>Ensure that staff performance appraisals are completed annually.</p> <p>90 days</p>

<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	<p>PA Low</p>	<p>The resident files reviewed were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. Progress notes reviewed did not have recorded time of entry.</p>	<p>Records overall within resident files were signed, however progress notes reviewed did not have recorded time of entry.</p>	<p>Ensure all progress note records have recorded time of entry.</p> <p>90 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>There was one resident self-medicating. The self-medication assessment had been completed by the RN, and authorised by the GP.</p>	<p>The self-medication competency had not been reviewed three monthly.</p>	<p>Ensure self-medication competencies are reviewed three monthly.</p> <p>90 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA Moderate</p>	<p>An electronic medication system has been implemented. All prescribed regular medications met the legislative requirements however, not all 'as required' medications had indications for use. Oxygen was not prescribed for use. The standing orders do not meet required standards.</p>	<p>(i) Oxygen had not been prescribed on the electronic medication system for a hospital resident on continuous oxygen. (ii) Three of seven medication charts on the electronic medication system did not have indications for the use of 'as required' medications. (iii) The standing orders format did not include the maximum dose, frequency or dosage for</p>	<p>Ensure the prescribing of all medications meets legislative requirements.</p> <p>30 days</p>

			all medications prescribed on the standing orders format.	
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>InterRAI assessments and long-term care plans reviewed were completed within 21 days of admission. Long-term care plans had been evaluated six monthly or earlier in resident files sampled. Initial assessments and initial care plans had not been completed for all residents within 24 hours of admission.</p>	<p>ARC D16.12c Initial assessments and initial care plan had not been completed for one rest home and one hospital resident on admission (within 24 hours).</p>	<p>Ensure all residents have an initial assessment and initial care plan completed on admission to cover a period of up to 21 days.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>Long-term care plans for one hospital level resident and one rest home resident reflected all the residents' supports and needs as identified through the assessment process. Short-term care plans are developed for acute changes in health status.</p>	<p>The long-term care plans did not reflect the resident's current needs for: (i) A hospital level resident with changes to care following a hospital admission. (ii) A hospital resident with changes to mobility and at high risk of a pressure injury (tracer resident). (iii) A rest home resident identified at high risk of falls. (iv) No diabetic management plan for two insulin dependent residents (one rest home</p>	<p>Ensure care plans reflect the resident's current health status.</p> <p>90 days</p>

			and one hospital).	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Residents interviewed stated their needs were being met. Relatives interviewed stated their relative's needs were being met and they were kept informed on any changes to their relative's health. Not all changes to health had been documented or implemented.	<p>(i) There were no documented interventions for three hospital level residents with unintentional weight loss.</p> <p>(ii) Fortnightly weights had not been completed as per short-term care plan for one rest home resident (tracer) with weight loss and the short-term care plan had not been reviewed to reflect current weight loss.</p>	<p>Ensure interventions for changes to health status are documented and implemented.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	There is an annual report of hot water temperatures that identify some temperatures are above 45 degrees Celsius. A plumber has been contacted and corrective actions completed.	Hot water temperatures in resident areas have not been monitored monthly.	<p>Ensure hot water temperatures in resident areas are monitored monthly.</p> <p>60 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Low	The infection control quality goals for 2015 – 2016 are linked to the business plan and goals. The IC programme has not been reviewed annually.	There is no documented evidence of an annual review of the infection control programme.	Ensure the infection control programme is reviewed at least annually.

				180 days
<p>Criterion 2.2.1.1</p> <p>The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.</p>	PA Low	The restraint coordinator is a RN and understands the role and her accountabilities.	No job description defined the role and responsibilities of the restraint coordinator.	<p>Ensure that a job description for the restraint coordinator is in place</p> <p>90 days</p>
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>	PA Moderate	The service completes consents, however assessments have not been completed prior to the use of a restraint, in four restraint files reviewed. In one of three long-term care plans, risks have been identified and reflected. The use of restraint has been identified in two of three long-term care plans.	<p>(i) In the four restraint files reviewed, there were no documented assessments that meet criteria (a) to (h). (ii) Risks identified with the use of restraint had not been identified in the long-term care plans for two residents on restraint. (iii) The use of restraint had not been identified in the long-term care plan of one resident on restraint.</p>	<p>(i) Ensure that all restraint assessments are completed prior to the use of restraint. (ii) and (iii) Ensure the use of restraint and the risks associated with the use of restraint is documented in the resident's long-term care plan.</p> <p>30 days</p>

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

---

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

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

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

No data to display
--------------------

End of the report.