

# Heritage Lifecare Limited - Ellerslie Gardens Home and Hospital

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## 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Heritage Lifecare Limited
<b>Premises audited:</b>	Ellerslie Gardens Home and Hospital
<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: 2 August 2016 End date: 3 August 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	81

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Ellerslie Gardens Home and Hospital provides rest home level care for 43 residents and hospital level care for 54 residents and is privately owned by Heritage Lifecare Limited. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the services contract with the district health board. The audit process included review of policies and procedures, review of residents` and staff records, observations and interviews with residents, families, the facility manager, staff, clinical services manager and a general practitioner.

This audit has resulted in a continuous improvement in restraint minimisation and identified that an improvement is required around the interRAI assessments not being conducted within the required timeframes.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and family/whānau are informed of their rights during the admission process and ongoing residents' meetings. There are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service accessible throughout the service.

Residents and family/whānau receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure they receive services that respect their individual values and beliefs, including for those residents who identify as Māori. There are processes to access interpreting and translating services as required.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence was seen of informed consent and open disclosure in residents' files reviewed. There are advance care plans and advance directives that record the residents wishes, with these respected by the staff.

There is a documented complaints process in place that complies with the Code. There are no outstanding complaints.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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A business plan and quality and risk management plan is documented and includes the mission and goals of the service. There is a process in place for the regular reporting against these goals.

The facility is managed by an experienced and suitably qualified manager, who is a registered nurse.

Quality management data is collected and discussed at staff meetings and staff were able to describe this. There is an implemented internal audit programme. Corrective action plans are in place where necessary. Adverse events are documented and there is evidence of good follow-up of these. Open disclosure is documented as it occurs.

There are policies on human resources management. Practising certificates are current for all registered nurses, one enrolled nurse and associated health professionals. Staff records have the required information, including staff education records. Staff report good access to training. An orientation programme is in place and completed.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. The facility manager and senior staff are rostered on call after hours. Care staff reported there are adequate staff available.

The privacy of residents' information is maintained in a secure manner. Residents' files are well presented and easy to navigate and records are integrated.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Entry to the service is clearly defined in policies. If a potential resident is declined entry to the service, this is recorded and the referrer informed.

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring hospital and rest home level care. Staff are qualified to perform their roles and deliver all aspects of service delivery. The facility manager and clinical services manager oversee the care and management of all residents, along with a team of staff. All residents are assessed on admission and assessment details are retained in the individual resident's record.

The residents' care plans document the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The service uses a mix of electronic and paper based assessment tools. The residents, and where appropriate the family/whānau, are involved in the care planning and review.

The activities available are appropriate for residents requiring hospital and rest home level care, including the needs of younger people under the age of 65. The programme is a strength of the service and meets the interests of the residents.

The service has implemented a web based medication management system that complies with current legislation. Staff who assist in medication management are assessed as competent to perform their role. There is a process in place for residents to safely self-administer their medications.

The menu plans have been reviewed by a dietitian. Each resident is assessed by the RN and clinical services manager on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. The kitchen complies with current food safety legislation and 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.		Standards applicable to this service fully attained.
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Policies and procedures are available to guide staff in the safe disposal of waste and hazardous substances. Appropriate supplies of personal protective equipment are readily available for staff use.

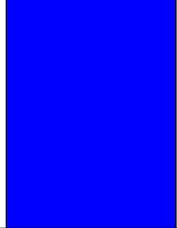
The building complies with legislation and has a current building warrant of fitness displayed. Clinical equipment has a current calibration. Electrical safety checks of electrical appliances have been undertaken in the last six months. The security arrangements and practices are appropriate and include surveillance cameras monitoring communal areas and the entrance.

There are adequate numbers of accessible toilets and showers located in close proximity to each service area. All individual rooms have hand-basins. Provision for visitors and family are located around the facility. Call bells were present in the bedrooms and bathrooms. Personal space was sufficient for residents, including those who required staff assistance or the use of mobility devices. There are separate lounges and dining areas. There is good indoor/outdoor flow with courtyards and garden areas for the residents and their families to use. The facility has adequate heating and ventilation.

Cleaning and laundry services are provided by employed staff. These services are monitored through the internal audit programme and resident satisfaction survey process. Residents and family members interviewed confirmed the facility is kept clean.

Emergency policies and procedures provide guidance for staff in the management of emergencies. There is an approved fire evacuation plan and fire evacuation drills are conducted at least six monthly. There are sufficient supplies available on site for use in the event of emergency or an infection outbreak.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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The service has documented policies and procedures for restraint minimisation and safe practice. Staff confirmed that enabler use is voluntary and the least restrictive option. Four residents were using enablers at the time of the audit. Staff demonstrated a sound knowledge and understanding of restraint and the use of enablers.

An effective quality improvement programme has been in progress to reduce the number of restraints, as verified in the quality records and restraint register maintained. There are currently four residents using a form of restraint for safety purposes. They are monitored closely. Monthly restraint audits are completed and reported to the organisation's quality and compliance manager.

## Infection prevention and control

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

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff.

Infection control education is provided by the infection control coordinator who is responsible for infection prevention and control activities. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. General practitioner (GP), or other specialised input, is sought as required. Staff and residents reported that they are informed of any infection issues 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>	1	48	0	1	0	0	0
<b>Criteria</b>	1	99	0	1	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)
<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>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme. Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents interviewed reported that they understand their rights. The relatives interviewed reported that residents are treated with respect and dignity.</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>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where applicable, this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. Advance directive and advance care</p>

		<p>plans are used to enable residents to choose and make decisions related to end of live care. The files reviewed have signed advance directive forms and advance care plans that identify resident wishes and meet legislative requirements</p> <p>Residents and family/whānau (where appropriate) are included in care decisions.</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>Advocacy information is available in brochure format at the entrance to the facility. Residents and family/whānau are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The staff interviewed reported knowledge of residents' rights and advocacy services.</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>Residents reported they are supported to be able to remain in contact with the community through outings and walks. Policy includes procedures to be undertaken to assist residents to access community services and a van is available for hire.</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>There is a complaints and concerns policy which meets the requirements of the Code of Rights. There is a flowchart associated with the policy to assist staff in understanding the process for complaints management. Residents and their families receive a copy of the policy in the welcome pack and there are copies throughout the facility.</p> <p>All concerns and complaints are recorded and managed in the same way. A register is maintained by the facility manager and a weekly report is provided to head office and to the quality and compliance manager. This is a new quality initiative. The register is updated continuously and all dates and actions taken are accurately recorded.</p> <p>Training on the complaints policy and open disclosure is provided to staff annually. There are no outstanding internal or external complaints.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families (as confirmed by interview with the</p>

<p>Consumers are informed of their rights.</p>		<p>facility manager (FM)). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Education is held by the Nationwide Health and Disability Advocacy Service annually.</p> <p>Residents are addressed in a respectful manner as was confirmed in interview with residents and relatives.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of resident related information. The resident's interviews and files reviewed evidenced that the individual values and beliefs of the residents are respected. There were no concerns expressed by the residents and family/whānau about abuse or neglect</p> <p>Staff interviewed report knowledge of residents' rights and understand dignity, respect and what to do if they suspected the resident was at risk of abuse or neglect.</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>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Māori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery/decision making is sought if applicable.</p> <p>The residents who identify as Māori report the services meet their needs, though they would prefer to be residing with whānau. The file reviewed of a resident who identified as Māori, reflects Tikanga best practice.</p> <p>The in-service education programme includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Māori and the importance of whānau.</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 cultural and/or spiritual needs of the resident are provided for in consultation with the resident and family as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Residents reported that their individual cultural, values and beliefs are met. Staff confirmed the need</p>

		to respect the individual culture, values and beliefs of residents.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	The employment position description and the Code of Rights define residents' rights relating to discrimination. Staff interviewed stated they would report any inappropriate behaviour to the RN. The staff contracts and files record that professional boundaries are included in contracts and the RNs have attended the required Nursing Council of NZ Code of Conduct training. There was no evidence of any behaviour that required reporting and interviews with residents and families/whānau indicated no concerns.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	The service has policies and procedures based on evidence based practice. The planned yearly education programme reviewed included sessions that ensures an environment of good practice. The service has access and support from visiting specialist nurses, palliative services and mental health teams. The GP visits the service at least weekly. Residents' and relatives' satisfaction surveys evidenced overall satisfaction with the quality of the care and services provided.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The cultural policy notes interpreters will be accessed if required. Prior to admission of residents who do not speak English, a senior staff member will offer the availability of the interpreting services to the resident and/or their family. This service can be contacted through the DHB. Files sampled of residents who do not speak English show there are effective methods of communication implemented.</p> <p>Evidence was seen that all aspects of care and service provision are discussed with the resident and their family/whānau prior to/or at the admission meeting. The residents and family/whānau report that communication is open and honest. Open disclosure is documented and is noted on incident forms.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The business plan for 2016 – 2017 was sighted which defines the scope, direction and objectives of the organisation as well as the monitoring and reporting against the objectives. Six main objectives have been set for the next 12 months. Staff interviewed understand the mission statement and this is documented in the service information brochures.</p> <p>The facility manager provides a weekly report to senior management (head office) and the quality and compliance manager, which covers occupancy levels, general comments on resident and staff</p>

		<p>movements, health and safety and compliance issues (incidents and accidents) new risks identified and any outstanding issues. Any items inclusive of compliments and complaints, issues with training, property and environment are transferred onto the organisation`s risk register to ensure it is current at all times. There is a weekly operations meeting to review the weekly reports and discuss any issues. Feedback from the Board is sent to management and onto the facility manager as part of the quality improvement process.</p> <p>The monthly report reviewed is based on clinical indicators and interRAI. Included in this monthly report are any falls with and without injury, pressure injuries, Infection control, wound and acquired infections, and the clinical services manager sends a narrative report with the data report to the quality and compliance manager.</p> <p>The facility manager is a registered nurse with a current annual practising certificate and management experience. In addition to this, the facility manager is a trained Aged Care Education (ACE) and Careerforce assessor, a qualified vaccinator and has completed preceptor training in 2016.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the facility manager the clinical services manager supported by the operations manager performs this role. The clinical services manager interviewed confirmed the responsibilities for this role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a quality and risk management framework which includes the quality and risk management plan. It is detailed and specifies the roles and responsibilities of all staff members, in particular the facilities manager and the clinical services manager.</p> <p>The facility manager develops the quality plan and goals, maintains the document management and control in the facility, and is responsible for monitoring and reporting progress against the quality goals in the weekly facility manager`s report.</p> <p>The clinical services manager is responsible for providing leadership in the facility and for the implementation of the plan, providing educational support for staff and registered nurses. Any issues or risks are reported to the facility manager.</p> <p>Document control is managed by the organisation`s quality and compliance manager. All documents</p>

		<p>are updated and sent out as a memo with instructions for replacement in the hard copy manual. The facility manager is responsible for sending back a declaration that the documents have been updated. The policies and procedures reviewed are relevant to the scope and complexity of the service and reflect current accepted good practice.</p> <p>Terms of reference are documented and there is an internal audit schedule labelled as a quality improvement plan. This sets out a comprehensive programme of audits across the year to monitor all aspects of service provision. Results are collated; analysed and relevant outcomes are fed back to staff. Training is provided to all staff annually on quality and risk management inclusive of incidents, accidents, health and safety, complaints and hazards.</p> <p>Resident surveys are completed annually and resident meetings are held monthly.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Adverse events are documented on an incident/accident form and these are followed up by the facility manager. Forms are well annotated with follow-up actions. All serious incidents/accidents are reported to the registered nurse or the clinical services manager on duty. Staff confirmed that they are made aware of their responsibilities in this regard during their orientation and in policy and procedures.</p> <p>The facility manager interviewed is fully aware of the essential notification requirements and these are documented in policy. The facility manager advised that there have been notifications of significant events made to the Ministry of Health or other agencies.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are policies and procedures on human resources management. Annual practising certificates of all RNs and one enrolled nurse were verified as were those for all associated allied health professionals. The skills and knowledge required for each position within the service is documented in job descriptions which were evident on each personal record sighted. All staff have been police vetted.</p> <p>An orientation process is available and covers all essential components of the services provided. One newly appointed staff member interviewed found the information provided to be informative and supportive. Staff performance appraisals are performed at the end of orientation and annually</p> <p>There is an education plan for the next two years with several sessions confirmed with speakers. The 2016 programme was reviewed and evidenced that education is provided, in house, on line and by staff visiting external facilities. The individual records of education are maintained for each staff member and were reviewed. All relevant staff have medication competencies. Twenty-three staff have completed first aid. Two registered nurses are fully trained in the interRAI assessment</p>

		programme (the service has trained 16 registered nurses and 14 have since resigned). Staff interviewed reported that they had good access to education and enjoyed the programme.
<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>There is a documented allocation of staff to complete the duty rosters. This document states that 'a base roster showing staff designations and hours are set according to the needs of the client groups, individuals and numbers'. This takes into account the acuity levels of residents in the rest home and hospital wings. An electronic tool, based on the indicators for safe staffing is used by the facility manger in conjunction with the clinical services manager to prepare the rosters fortnightly in advance.</p> <p>Care staff interviewed reported that there is adequate staff available and that they were able to complete the work allocated to them. Residents and families interviewed reported that there was enough staff to provide them or their relative with adequate care. Observations during the audit confirmed adequate staff cover is provided.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Personal information is entered in all residents` records reviewed. Records reviewed evidenced entries being documented which are legible with signatures and staff designations included. All individual records are integrated with divisions labelled accordingly.</p> <p>The records are stored in the nurses` stations which have locked access. Residents` service agreements and other personal documents are stored in the facility manager`s office. Resident information is not displayed in public view without consent being obtained.</p> <p>A system is in place for accessing archived records if and when required.</p> <p>A resident register is maintained by the administrator.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The admission policy includes the procedure to be followed when a resident is admitted to the home. The admission agreement contains all required information and is based on the Aged Care Association agreement. Entry screening processes are documented and communicated to the resident and their family/whānau to ensure the service is able to meet the needs of the resident. The residents and family/whānau reported the admission agreement was discussed with them prior to admission and all aspects were understood.</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>All residents' exit, discharge or transfer is documented using specific forms. The service utilises the transfer forms approved by the DHB and this was confirmed in files reviewed. Known risks are identified to the place of transfer in order to manage the resident safely. Expressed concerns of the resident and family/whānau are clearly documented including advance directives and EPOA documentation. This was confirmed during residents' file reviews.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Policies and procedures describing safe medication management are implemented by the service. The service has implemented a web based medication management and charting option.</p> <p>There is policy in place which describes the process to follow for residents who are deemed competent to self-administer medicines (as evidenced in two resident charts/medication records).</p> <p>With the exception of liquid medicines and stock medications, such as antibiotics, medicines are supplied by the pharmacy in a pre-packed robotics administration system for individual residents. Medications are checked for accuracy by the RN when delivered, with this recorded on the electronic medication record. Safe medicine administration was observed at the time of audit.</p> <p>The medicines, controlled drugs and medicine trolley were securely stored. The management of the controlled drugs meets legislation and best practice guidelines. Two staff signs the controlled drug register when medication is given and a physical check is undertaken weekly and six monthly.</p> <p>All the medication records sampled have prescriptions that complied with legislation and aged care best practice guidelines. The GP has conducted medication reviews for all residents within the last three months.</p> <p>Medication competencies were sighted for all staff who assist with medicine management.</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>Policies and procedures implemented cover all aspects of food preparation. Documentation identifies that safe food hygiene management practices are followed.</p> <p>The menus were reviewed by a registered dietitian in the last two months as being suitable for the residents living in a long term care facility. The cook stated that food is produced in accordance with the menus. There is a documented cleaning programme implemented.</p> <p>The kitchen has dietary information for all residents and their likes and dislikes are catered for. Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. The residents and family/whānau reported being overall satisfied with the meals and fluids provided. One resident</p>

		<p>did comment that they thought the portion sizes were too small, with all other residents reporting large portion sizes.</p> <p>Food, fridge and freezer recordings are undertaken daily and meet requirements. The kitchen staff have completed safe food handling courses.</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The facility manager reported that the needs assessment team at the local DHB usually ring and a telephone discussion verifies the suitability for admission, with the facility and clinical services manager assessing the potential resident's suitability prior to admission through visits to the resident in the acute care hospital setting. There is a folder which contains documentation of all enquiries and the action taken if the admission is declined. This included contacting the referral agency. The service was not able to provide services to a recent bariatric resident. The facility manager reported that they refer residents to different levels of care if they are unable to support the resident (such as psychogeriatric to secure dementia care).</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>The initial nursing assessment includes use of the organisational paper based assessment tools, and these include falls risk, pressure area, and pain assessment. There is evidence of family/whānau involvement in the assessment process. Though the organisation has completed initial and ongoing assessments using their own assessment tools, the interRAI assessments have not been completed within the contractual timeframes. There is also inconsistency in the assessments of pressure injuries.</p>
<p><b>Standard 1.3.5: Planning</b></p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>In all files reviewed evidence was sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these include falls risk, pressure area risk and pain management. The assessment outcomes from the interRAI assessment process are included to update the care plan.</p> <p>All health professionals document in the resident's individual clinical file and have access to care plans and progress notes as part of the integrated file system. Documentation in files reviewed included nursing notes, medical reviews and hospital correspondence. The residents reported that they are included in the care planning and are aware of any changes and these are discussed with them. Care staff reported they are informed of any changes to care plans at shift changeover. The residents report satisfaction with the care provided.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The care plans reviewed were individualised to show interventions put in place to contribute to meeting resident goals. Information sighted on care plans was congruent with assessment findings. Residents and family/whānau interviewed reported satisfaction with the services they receive. The clinical staff reported that they are informed of any care plan changes at the shift hand over and have relevant in-service education as required, specific to any new interventions.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities coordinator plans activities to meet the resident's abilities; this includes the needs of the younger people at the service. Information gained by an activities assessment and resident's history assessment is used when developing the activity plan. The activities coordinator reported they focus on giving the residents back some independence by focusing on activities that are meaningful.</p> <p>There are planned activities that cover physical, social, recreational and emotional needs of the residents. The activities programme is an evolving plan to match weather conditions and resident's abilities. The activities coordinator visits each resident in the morning to remind them of the planned activities for that day and ask for any further suggestions for the day's activities. Feedback received from the residents and family/whānau is taken into account when planning activities. The residents (including younger people) report that the activities programme is of interest to them.</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>Individual short term care plans were seen for wound care, infections and weight loss. These are kept in the resident's folder and during each shift documentation is made in the file as required.</p> <p>Long-term care plans are reviewed every six months or earlier as required. Evidence was seen of family involvement in the care reviews. In files reviewed there was evidence of documentation if an event occurred that was different from expected and required changes to service. The residents and family/whānau reported that they are given the opportunity to be involved in all aspects of care and reviews. The clinical staff interviewed have knowledge of the care plan documentation requirements.</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</p>	<p>FA</p>	<p>Residents may use the GP of their choice if they do not wish to access the main GP that regularly visits the service. Referrals to other health providers are supported by the organisation and facilitated by the GP and RNs. This was confirmed in residents' file reviews and during resident and family/whānau interviews.</p>

appropriately facilitated, or provided to meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported in a timely manner. Material safety data sheets are available in the laundry and accessible to staff. No products are decanted other than under the manufacturer's instructions in the laundry for the automatic dispenser.</p> <p>There is provision and availability of protective clothing which was observed throughout all areas of the facility. Staff interviewed were aware of using protective clothing appropriately.</p> <p>Training is provided to all staff annually on the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed that expires 10 March 2017. Review of documentation provided evidence there are systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a maintenance programme in place for the building, equipment and renovation. The maintenance person was interviewed and validated that a new system is in place which is working effectively. Testing and tagging of essential equipment is current and on the maintenance plan reviewed.</p> <p>There are external courtyard areas available that are safely maintained and are appropriate for the resident group. The environment is conducive to the range of activities undertaken. Residents are protected from risks associated with being outside. Shade is available and utilised in the summer months.</p> <p>Residents interviewed confirmed and were observed to move freely around the facility and that the accommodation met their needs.</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</p>	FA	<p>Most rooms have a full ensuite bathroom with wet area showers, toilets and hand-basins. Rooms without ensuite have hand-basins and there are adequate numbers of bathrooms and toilets in close proximity to the bedrooms. On one wing only (wing 5), all rooms have a toilet in each room. There is a shower suite and additional toilet/shower areas. These were adequate for the number of residents.</p> <p>Approved secured handrails are provided in all toilet/shower areas and other equipment/accessories are available to promote residents' independence.</p> <p>Visitors' toilets are identifiable and located around the facility.</p>

requirements.		
<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>On visual inspection of the facility there is adequate personal space provided to allow residents and staff to move around within their rooms safely. Two residents interviewed, one in a wheelchair and one using a walker, spoke positively about their accommodation. Rooms are personalised with furnishings, photographs and other personal items. There is adequate storage for walkers and motorised wheelchairs and a designated area for charging the batteries at night or as required.</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>There are good spaces for residents to enjoy activities, dining and relaxing, that are easily accessible by everyone. Residents are able to access areas for privacy when required. Furniture is appropriate to the setting and arranged in a manner that enables residents to mobilise freely. Residents reported they enjoy their environment and are able to have visitors at any-time.</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 guidelines for appropriate use of chemicals and cleaning solutions. These include information about how to handle these products and directions to use material data safety sheets from the product provider, and use of personal protective equipment and clothing is encouraged and promoted.</p> <p>Training is provided to staff annually on the use of chemicals and to care and laundry staff on laundry protocols/systems in place.</p> <p>All laundry is managed by staff on site. The laundry is managed by experienced staff during the daytime and care staff assist during the after-hours. No personal clothing is laundered during this time only bed linen and towels. There is a lockable cupboard for all cleaning and laundry chemicals and all are appropriately labelled.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	FA	<p>The service has a fire plan approved by the NZ Fire Service and is fitted with a sprinkler system. The approved fire evacuation letter reviewed was dated 5 November 2013. A fire drill was last held twice on the 10 March 2016 and records of attendance were sighted. The orientation programme includes health and safety, fire and security training.</p> <p>There is a policy for emergencies as part of the quality and risk management plan and additional</p>

<p>emergency and security situations.</p>		<p>information is available in the health and safety manual to direct and guide staff. The plans sighted include the requirements of this standard. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including lighting, torches, food, water, blankets and gas for cooking. The emergency cupboard was sighted and a checklist of supplies is maintained on a regular basis.</p> <p>There are call bells to alert staff in each bedroom, bathroom and service area. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</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>	<p>FA</p>	<p>Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All rooms have heaters gas and /or electric which are wall mounted. New heat pumps have been installed in the main dining/lounge areas. All residents have good sized windows in each bedroom to provide natural light and a ranch-slider which opens to the outside.</p> <p>The residents and family members interviewed confirmed the facility is normally warm and well ventilated.</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>	<p>FA</p>	<p>The clinical services manager is the designated infection control coordinator. They have a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meetings and the combined infection control/quality/safety committee meetings. The head office receives the monthly quality, risk and infection control issues. The review of the infection control programme was conducted within the last 12 months; this was last conducted in June 2016. The programme reviews the effectiveness of the infection control programme, education, surveillance and equipment.</p> <p>There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise relatives not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. Staff demonstrated good knowledge and application of infection prevention and control principles.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control</p>	<p>FA</p>	<p>The infection control coordinator oversees the infection control programme, with implementation the responsibility of all staff. Infection control matters are discussed at the monthly staff meeting and evaluation occurs at the two monthly safety committee. If the infection control coordinator requires additional advice or support regarding infection prevention and control they can access this through the DHB, GP or specialist staff within the Heritage Lifecare group.</p>

programme and meet the needs of the organisation.		
<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	<p>The infection control policies and procedures have been developed by the organisation and reflect current accepted good practice. The service has access to good practice resources from a specialist infection prevention specialist with quality reporting to the head office. The policies are appropriate to the services offered by the facility and reviewed by the head office.</p> <p>Staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions according to the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.</p>
<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 conducts most of the infection control education. There are some visiting specialists who provide infection control education. The infection control coordinator demonstrated current knowledge in infection prevention and control. They have attended ongoing education on current good practice in infection prevention and control.</p> <p>As required, infection control education can be conducted informally with residents, such as reinforcement of infection control practices with washing hands, blowing noses, cough etiquette and personal hygiene when assisting with toileting.</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>The service uses standardised definitions applicable to aged care that are provided by the external benchmarking service to identify infections. The type of surveillance undertaken is appropriate to the aged care service with data collected on urinary tract infections, influenza, skin infections and respiratory tract infections. There is monthly collection and collation of the types and numbers of infections in both the rest home and hospital services. The data and reporting of the statistics and analysis is provided to the organisational wide governance/quality team. The outcomes are fed back to the staff at the next staff meeting. The GP reviews the infection trends for the residents at the three monthly GP reviews. The infection surveillance records include the review and analysis of the data. With an increase in the number of urinary tract and chest infection in June 2016, the service implemented actions to reduce the recurrence of spread of the infections.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies and procedures for the use of restraints and enablers. This includes having a restraint coordinator, for which there is a position description. There is a restraint approval group.</p> <p>There are currently four residents using a form of restraint and four using enablers. These figures provide an example of restraint minimisation in a large care facility.</p> <p>Staff interviewed are fully informed of the differences and that an enabler is used as a voluntary option. There is a restraint register/folder in each service area and the use of restraint/enablers is reviewed three monthly.</p> <p>The clinical service manager interviewed is the restraint co-ordinator. The GP and the approval group sign the required documentation when required.</p> <p>Education is provided on de-escalation techniques as part of de-escalation workshops held for staff. A continuous improvement has been attained (2.2.5.1) in relation to the comprehensive reviews the service undertakes to minimise restraint use.</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>	<p>FA</p>	<p>After a comprehensive assessment is performed by the registered nurse and/or clinical services manager approval is sought by the approval group. The approval group consists of nursing management, the resident's general practitioner, physiotherapist or other allied health professionals as well as the resident concerned, their welfare guardian/representative, a cultural advisor as required, and/or a resident advocate if available. The cultural safety policy refers to incorporating the resident's culture, values and beliefs into the restraint assessment process.</p> <p>The approval process is documented to guide staff. A restraint decision making process flow chart is also available.</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>	<p>FA</p>	<p>The assessment process identifies any potential risks related to the use of restraint. The assessment is undertaken by the clinical services manager who is the restraint co-ordinator and this is identified in the role description. Pre-restraint/enabler assessment includes a-h of this criterion as sighted in restraint documentation. Policy identifies that the resident/family/whānau input is identified on each initial and updated assessment. Approval/consent is signed off by the relevant person (the resident for an enabler and/or family/whānau/representative and the approval committee representative or the GP).</p>

<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The service ensures all procedures in place are continually monitored by the restraint approval group. Policy is reviewed annually. 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. A restraint monitoring form is utilised and regular checks are made when the restraint or enabler is in use. The forms used were reviewed. All checks were documented. All restraint/enablers are used for safety reasons only. The restraint register is kept updated. There is a restraint folder in each area of the service. Staff education is evaluated as appropriate for the type of restraint used and all requirements of the standard are effectively met.</p> <p>The caregivers interviewed confirmed they understand and are aware of the need for regular monitoring and that safety for residents is not compromised. Restraint is used as a last resort, with the least amount of force, and all other interventions have been considered or attempted.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service undertakes an evaluation of all restraint use at a minimum of three monthly. Family/whānau or a nominated representative is included in all evaluation processes if agreed by the resident. Policy identifies that a resident/family/whānau are involved in and sign consent for ongoing restraint deemed as appropriate. Evaluation is undertaken to gauge the effectiveness or otherwise of restraint/enabler as an appropriate and safe intervention. The form is signed if there is agreement with the decision made.</p> <p>The restraint co-ordinator interviewed stated that reviews would be undertaken earlier if restraint is no longer required or if it does not appear to be keeping the resident safe as it was intended to do. The resident and family/whānau as appropriate would be fully informed of this decision. The resident has a right to a support person/advocate during the evaluation process and this is encouraged by the service providers. Additional education would be provided to staff as needed.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>CI</p>	<p>The service is able to demonstrate via the documentation sighted that three monthly monitoring and annual quality reviews are conducted related to the use of enablers/restraint. Quality review findings and recommendations are used to improve service provision and resident safety. Policy indicates that comprehensive reviews are completed annually to cover and meet a – h of this criterion.</p> <p>The service can demonstrate that annual policy and procedure reviews are also undertaken and that restraint, in the form of requested enablers/restraint are only used for safety reasons. If compliance is not obtained action is undertaken along with additional staff education.</p>

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## 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 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery</p>	PA Low	<p>In files reviewed, the assessment information was used as part of care plan development. All of the files reviewed evidenced an interRAI assessment or reassessment, though these have not been completed within contractual time frame requirements. None of the files reviewed had an initial interRAI assessment conducted within 21 days of admission. All files reviewed did have an interRAI assessment, though these have been conducted at different times to the care plan evaluation process. Any triggers and assessment protocols that were identified in interRAI have been used to add updates to the care plan. The service has developed an action plan for ensuring the time frames for the initial and re-assessments using interRAI to align with the six monthly evaluation of resident's care plans. As the service has identified the timeliness as an issue and now have all residents assessed using interRAI and have developed an action plan to address the shortfall, the risk rating has been assessed as low.</p> <p>The file reviewed of a resident with a pressure injury, has inconsistent assessment classification of the stage of the wound. In one assessment the pressure injury is</p>	<p>There were inconsistent assessments of a pressure injury.</p> <p>The interRAI assessments have not been conducted in the required time frames.</p>	<p>Provide evidence of consist pressure injury assessment using best practice guidelines.</p> <p>Ensure the ongoing interRAI initial assessments</p>

planning.		<p>assessed as an open stage (with broken skin, this would suggest a stage two injury: this was amended on the assessment at the time of audit), the wound treatment plan describes the wound as excoriation and the nutritional assessment as a stage three pressure injury. The quality data has the wound recorded as a stage two pressure injury. One other file of a resident with a 'diabetic ulcer' and treatment that reflects a mix aetiology ulcer has the wound described as a 'pressure injury' on the care plan.</p>		<p>and re-assessments are completed within the contractual time frames.</p> <p>180 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p>	CI	<p>The service has introduced six monthly restraint audits with the aim of meeting the requirements of the restraint minimisation and safe practice standard and policies and procedures which were reviewed as part of a documentation check and general observations. A restraints standards report template is completed six monthly by the restraint co-ordinator on types of restraint used, difficulties experienced and training provided. Recommendations are made for improving the practice of restraint. The report template is sent to the quality and compliance manager for the organisation along with the quality improvement action form. A graph is developed to show the reduction of restraint use. All restraint committee meetings are able to be followed through with meeting minutes dated and signed, and education is continually evaluated as part of the quality monitoring programme. Resident case studies are discussed and relevant decisions are made</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate achievement beyond the expected full attainment for the high standard of documentation for managing all stages of restraint minimisation and safe practice. The appropriate corrective action planning has been undertaken as part of the quality monitoring system to improve the safety and delivery of services to residents when a restraint and/or an enabler is being used. The introduction of the quality improvement action form which identifies a problem, action to be taken, by whom, by when and with the committee/group evaluation and recommendations has reduced the number of residents using restraint in this facility. A graph provides</p>

<p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>		<p>collaboratively by the approval group if changes are to be effectively made. Feedback is provided to staff to maximise safety and awareness. Professional advice and input is provided on how to manage some individual residents as required from allied health professionals. A team approach is encouraged.</p>	<p>evidence that displays a quality improvement approach in restraint minimisation and safe practice and a reduction in restraint/enabler use since February 2015 to May 2016. Information has been fed back to staff and education provided from external providers has been beneficial.</p>
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End of the report.