# Liberty 2000 Limited - Kintala Lodge 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 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Liberty 2000 Limited

**Premises audited:** Kintala Lodge Rest Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 21 July 2016 End date: 22 July 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 21

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Kintala Lodge Rest Home (Kintala) continues to provide secure dementia rest home level care for up to a maximum of 25 residents. This certification audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board.

The district health board requested that this audit process include verifying that the measures put in place after a 2014 complaint were still in effect. These were confirmed and relevant evidence is contained in the body of this report. Evidence was collected by reviewing policies and procedures, reviewing staff files, observations, and interviews with family/whānau, management, staff and a general practitioner. Resident interviews did not occur because of their impaired cognition and communication. More time was spent observing staff interactions with residents.

Feedback from residents and family/whānau members was very positive about the care and services provided.

No areas for improvement were found during the audit. The outcome from a staff education project is rated as continuous improvement.

## Consumer rights

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Staff demonstrated good knowledge and practice of respecting residents’ rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner’s (HDC) Code of health and Disability Services Consumers’ Rights (the Code). Families and residents interviewed expressed satisfaction with the caring manner and respect that staff show towards each resident.

There were no residents who identified as Maori residing at the service at the time of audit. There are no known barriers to residents accessing the service. Services are planned to respect the care required, culture, values and beliefs of all the residents as individuals and as a collective.

Written consents are obtained from the residents’ families/whanau, enduring power of attorney (EPOA) or appointed guardians, when necessary.

Residents are encouraged and supported to maintain strong community and family links.

The documented complaint management system is congruent with Right 10 of the Health and Disability Consumer Code of Rights. A small number of complaints have been received and resolved since the previous audit and the manager has not been notified of any complaints received by the Office of the Health and Disability Commissioner. Relatives interviewed during the audit were aware of how to raise concerns and complaints.

## Organisational management

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

Kintala has well established quality and risk management systems which include internal audits of all service areas, and identifying, reporting and remedying service deficits.

Adverse events are reliably reported, analysed and evaluated by the senior management team. Event reports record who is notified about adverse events. The general practitioner and families confirm they are informed in a timely manner when events occur. Positive comments were made about the frequency and extent of communication initiated by staff in relation to the progress and wellbeing of all residents. The general manager understands the regulations regarding section 31 notifications. A notification was submitted to the Ministry of Health and the district health board in March 2016.

There is a low turnover of staff and when new staff are required they are recruited according to best practice and legislation. Staff training in relevant subject areas is occurring in new and improved ways at regular intervals. All staff are supported and encouraged to attend ongoing performance development and achieve the dementia qualifications required for this type of service. The numbers of skilled and experienced staff on site to meet the needs of residents 24 hours a day seven days a week meet the contract requirements.

Management of consumer information meets the required standard.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

Pre-admission information clearly and accurately identifies the services offered. The service has policies and processes related to entry into the service.

Residents are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops a care plan specific to the resident. This is developed with the resident, family and existing community supports and health care professionals. When there are changes to the resident’s needs a short term plan is developed and integrated into a long term plan, as needed. The service meets the contractual time frames for all short and long term care plans. All care plans are evaluated at least six monthly. All residents have ‘interRAI’ assessments completed and individualised care plans related to this programme.

Residents are reviewed by their GP on admission and assessed thereafter either monthly and or weekly depending on their health status and needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

Activity coordinators provide planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes accommodated. The service has a four week rotating menu which is approved by a registered dietitian. Resident’s nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

## Safe and appropriate environment

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

Systems for management of waste are effective. The facility is being well maintained. There is an efficient reactive maintenance process and a long term maintenance programme is in place. Residents are being provided with safe, secure and appropriate facilities that are furnished with their needs in mind. Upgrades of furniture and fittings are occurring. Medical equipment is checked and calibrated at least annually. A registered electrician tests and tags all electrical devices yearly. There are sufficient toilet, shower and hand washing facilities and hot water is tested weekly to ensure it is being delivered at a safe temperature. All bedrooms are spacious and furnished in ways that reflect each residents' needs and known likes. The external environment is safe and accessible for residents who were observed to utilise the outdoor areas.

Cleaning and laundry services are safe, hygienic and effective.

Resident areas are well lit and ventilated by opening windows and doors. The home is comfortably heated.

## Restraint minimisation and safe practice

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

Kintala Lodge has established and well known processes related to the safe and appropriate use of restraint and enablers which meet the requirements of this standard. On the days of audit the restraint register listed two residents assessed and approved for use of safe seats. The documentation and methods that were used to assess, and obtain consent and approval for the use of these restraints comply with the standard. Staff regularly monitor the resident’s responses and document the care and interventions provided while these safe seats are in use. There was evidence that each restraint intervention was being evaluated and reviewed at a suitable frequency for the risks and changing conditions of the individual resident. The service provider conducts an annual quality review which considers the extent and effectiveness of all restraint activity.

## Infection prevention and control

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

The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff, and when appropriate, the residents and their families. There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported to staff, family and visitors where appropriate

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 100 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). New residents and families are provided with a copy of the Code on admission and a copy is displayed on the main corridor wall in full view.  On commencement of employment all staff receive induction orientation training regarding residents’ rights and their implementation. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights in a manner that was individual to the resident’s needs. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.  The residents’ files reviewed had consent forms signed by the family and/or enduring power of attorney (EPOA). Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and families/whanau were actively encouraged to be involved in their relative’s care and decision making. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | All residents receiving care within the facility have appropriate access to independent advice and support, including access to a cultural and spiritual advocate whenever required.  Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff. The facility has access to an advocate through the district health board. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau interviews and documented in daily and planned activities in resident’s progress notes and care planning, such as church services. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints management process is clearly described. Advocacy and staff education on complaints management are discussed in the policy. The documented procedures are clear and meet the requirements of this standard, the provider’s contract with the DHB (ARC contract) and Right 10 of the Code.  The sighted complaints register contains sufficient detail about the complaints received since the previous audit (for example, dates, descriptions, investigations and outcomes). The district health board portfolio manager requested verification of ongoing remedial actions following a complaint in 2014 about the smell of urine. This was and still is related to some of the confused male residents urinating in hallways. The service provider has implemented the following improvements and continues to be vigilant. Toilet doors are readily distinguishable by colour and artwork, signs with arrows directing to toilets are on display, carpets are shampooed daily, new armchairs have been purchased and these are protected by chair pads, the walls and skirting boards have been varnished, staff have attended specialist education on managing toilet behaviour with dementia sufferers and staff are quick to remove and launder soiled linen and clothing. There was no odour of urine in the home on the days of audit. The most recent relative survey contained a positive comment about the cleanliness of the home and the absence of odours. A family member who visits frequently said the home compared favourably with other age care facilities in this regard.  Staff interviewed were informed about the complaints system and that when complaints are raised these are managed efficiently and effectively to reach resolution. Information about the complaints process is provided to families on entry to the service, via the admission agreement and in service information. Staff are informed about the complaints process during induction and they are reminded about these at staff meetings. Relatives interviewed confirm they are informed about the complaints system and would have no hesitation in raising concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the family on admission and is evidenced in the admissions agreement.  The family/whanau that were interviewed reported that the Code was explained to them on admission. The Code of Rights and process was also regularly discussed at family meetings. Family/whanau expressed that they were happy with the care at the facility and provided by the staff. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents’ files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The families/whanau interviewed reported that the staff are meeting the needs of their relatives.  The families/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident’s dignity, privacy and independence. At the time of the audit staff were seen to knock on residents’ doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.  No concerns in relation to residents’ abuse or neglect were mentioned. The family members reported that staff know their relatives well. This was also evidenced at the time of audit with observed interactions. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The senior registered nurse reported that there are no barriers to Maori accessing the service. At the time of the audit there were no Maori residents. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The spiritual, religious and cultural standard operating procedure documents that the admission process includes assessing specific cultural, religious and spiritual beliefs, which includes any cultural nutritional requirements. Staff liaises with family/whanau at time of admission and regular intervals to ensure cultural or religious visits continue as appropriate. Residents have access and are supported to attend services within the facility and in the community.  Education on cultural sensitivity and spirituality has been completed. Families interviewed were happy with the care provided by those staff who also identify with a different culture. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Family/whanau reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice was observed and evidenced in interviews with the registered nurses, caregivers and care planning process. Policies and procedures are linked to evidence-based practice. There are regular visits by residents’ GPs, links with the mental health services, hospice, the geriatrician and different DHB nurse specialists and consultants. Care guidelines are utilised as appropriate. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The families/whanau interviewed confirmed that they are kept informed of their relative’s wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents’ progress notes, accident/incident forms and at handover.  All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit all residents spoke English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Strategic planning is identified in the 2014-2015 business plan which includes goals and objectives related to service delivery. Risk management, vision and mission statements are documented and reviewed annually as part of the business planning process. Progress against goals is monitored by the general manager (GM) who meets bi-monthly with the other director and co-owner. Outcomes from these meetings are documented and show that all areas of service provision are discussed along with the detailed report provided by the RN.  The general manager and second in charge registered nurse are on site five days a week. Both have many years’ experience in the provision of dementia care. Personnel records show that the GM and the RN are attending education appropriate to their roles. Family members interviewed confirmed their satisfaction with all areas of service delivery and the ways in which their relatives’ needs are being met.  On the days of audit there were 21 residents, including one younger person funded by ACC. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The general manager states that the DHB is always notified about planned absences and delegates the RN as the acting manager. In most instances the second director is available for support. The two full time RNs provide cover for any unplanned absences. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Quality and risk management systems are well established understood and implemented by staff. The quality policy and current quality plan describe the philosophy and activities in place for monitoring and measuring the quality of services delivered and how risk is identified and managed. The system includes keeping policies and procedures updated, conducting regular internal audits, reporting incident/accident and health and safety matters, review of restraint and infection control data and complaints management. Although there were no residents with pressure injuries on site during audit days, documents revealed that when they occur, pressure injuries are reported as incidents, discussed at staff meetings, reported to the directors and are included in quality reports. Corrective actions are implemented when service monitoring or external feedback identifies service deficits. Quality improvement projects and other areas that have been identified for improvement are documented. The service provider is continuing to seek other, new ways to demonstrate their commitment to quality. All reporting is linked to management processes through the director’s bi-monthly meetings. This information is used to inform ongoing planning of services to ensure residents’ needs are met.  The service wide approach to risk management includes analysing incident reports to identify and communicate ongoing risks, maintaining the hazard register, and conducting environment checks. Staff are being kept updated about any actual or potential risks by the health and safety officer/general manager, via handovers, 1:1 discussions and at monthly staff meetings. This was confirmed in meeting minutes sighted and verified by staff interviewed. Falls, urinary tract infections and respiratory tract infections continue to be benchmarked by an offsite organisation against other like facilities and compared to previously collected data on-site.  All residents are regularly risk assessed for skin integrity, nutrition, falls, and challenging behaviour (for example, on admission and then three to six monthly or earlier if the residents condition changes). |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The accidents and incidents that were reported in 2015 -2016 contain a lot of detail and record where GPs or family have been notified. The RN collates all incidents monthly according to the number and type of incidents and where and when these occur. These are analysed to produce a narrative and statistical report which identifies trends, risk areas or where action is required and is presented to the directors for follow up and accountability. The service is benchmarking fall rates, and infection data with other similar services.  Interview and records reviewed showed that the manager is aware of the instances that require notification reporting. Notification to the district health board and the Ministry of Health about a missing resident occurred in February 2016 in accordance with the section 31 regulations. There is evidence of mitigating actions taken to prevent recurrence. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Review of human resource policies, five personnel records, organisational chart, and interviews with staff and the general manager reveals good employment processes. Each staff file contained a signed employment agreement, job description, evidence of police vetting, referee checks and a dated and signed orientation programme. The staff files showed that both RNs have current practising certificates. The general manager verifies other registered health practitioners are authorised to practice before allowing them to provide services.  The staff files and interviews with care staff confirm that orientation is planned, coordinated and effective. Orientation includes a series of practical and theoretical teaching sessions with follow up competency tests and questionnaires. Employment is not confirmed until the potential staff person demonstrates they understand the nature of the job and are suitable by working under supervision for at least two shifts.  All care staff and the RNs have either attained the required qualifications in dementia education or commenced training for this.  A recent quality project aimed at ensuring all staff are engaged with ongoing education has produced good results. This involved reviewing the methods for teaching staff and consulting with the night staff who were only attending compulsory training. Compulsory in-service includes fire drills, manual handling/safe lifting, medicine management and restraint minimisation. Attendance at monthly educational sessions shows a marked improved for 2016. The RNs take it in turn to work alongside and coach each caregiver before testing their knowledge and understanding with a quiz or competency assessment. The evening RN also prompts and reminds night shift staff about upcoming training.  In-service training is planned a year ahead, includes a range of subjects related to caring for residents with dementia and is flexible in allowing for additional topics to be included on the calendar when needed. For example, a specialised training in managing toileting behaviour in dementia sufferers was added in for July 2016.  Certificate sighted confirmed that one RN has completed interRAI training and the annual competency test has been completed and the other RN has almost completed the training |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy clearly describes a rationale based on known guidelines (for example, indicators for safe aged care and dementia care for consumers.) The roster and staff interviews confirmed that staff numbers are increased when resident acuity changes. There is one RN on site Monday to Friday during the day and another is rostered for evening shifts. Staff described a number of advantages from having RNs on site for more than 16 hours a day. The afternoon and night care staff are gaining 1:1 coaching, resident care and status at different times is being assessed by different RNs, and staff ability to manage the unexpected is improved. Two caregivers are rostered for every duty. The general manager is on site five days a week. Activities, cook, and domestic staff are allocated sufficient hours to provide services. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents’ needs. The RNs or the general manager provide after hours on call seven days a week. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all residents’ information sighted. Clinical notes were current and integrated with GP and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident’s record reviewed. No personal or private resident information was observed to be on public display during the days of audit. Archived records were being safely held on site for ten years. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The resident admission agreement is based on the Aged Care Association agreement. The residents’ records reviewed have signed admission agreements by the family or an enduring power of attorney (EPOA).  Vacancies are updated daily through Eldernet. The registered nurse if enquiries are made outside of working hours is able to show potential residents and/or their family members around the facility. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service uses the DHB’s processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident’s individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Communication between the two services and with the family occurs prior to transfer and any concerns are documented and included in the transfer information. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, the process when an error occurs, as well as definitions for ‘over the counter’ medications that may be required by residents. At the time of audit no resident was self-administering medications.  Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in a medicine trolley individually in the treatment rooms which is locked when not occupied. A locked safe is used for controlled medications and the medicine register was sighted. Medications that require refrigeration are stored in a separate fridge with recorded temperatures documented.  The 10 medicine charts sighted have been reviewed by the GP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and ‘as required’ (PRN) medications identified had the reason stated for the use of that medication. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident.  There are documented competencies sighted for designated care staff responsible for medicine management. The senior caregiver administering medicines at the time of audit demonstrated competency related to medicine management. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safety requirements. The cook interviewed had a very good understanding of food safety management and has completed ongoing food safety training.  There is a four week rotating menu that has been reviewed by a dietitian in 2015. Where unintentional weight loss is recorded, interventions are initiated and the resident is discussed with the GP.  A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.  The kitchen also offers residents a variety of cereals for breakfast, a main option for lunch including a desert and a lighter menu option for dinner. All main meals are supported by morning and afternoon tea which includes home baking.  All meals are cooked and served directly from the kitchen and served in the adjacent dining room. Residents have the option of trays in their rooms, however all residents are encouraged to have all their meals in the dining room to encourage appetites and socialisation. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The general manager and senior registered nurse interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found.  If the resident’s needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The service has implemented the electronic interRAI assessment and specific assessment tools for all residents remain paper based. Assessments are carried out by a registered nurse appropriate to the level of care of the resident and includes falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.  The residents’ files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident’s family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure injury risk assessments.  The family/whanau interviewed reported their relative receives ‘above and beyond the care required’ to meet their relative’s needs. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The five residents’ files reviewed have electronic care plans that address the resident’s current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in the residents’ files. Also evidenced is the assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The caregivers interviewed demonstrated knowledge about the individual resident’s they care for.  The residents’ files reviewed included diversional therapy care plans identifying the resident’s individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files showed input from the senior registered nurse, care and activity staff and medical and allied health services. The registered nurse and caregivers interviewed reported they receive adequate information to assist with the resident’s continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication book.  The family/whanau interviewed reported they were very happy with the quality of care provided at the service. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.  As observed on the days of the audit, the registered nurses and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that as reflected in the resident’s care plan. The residents’ files showed evidence of discussions and involvement of family. The family/whanau interviewed reported that the staff knew their resident very well and had no concerns with the care they received.  The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident’s assessed needs and desired goals. The registered nurse and caregivers interviewed reported they have input into residents’ care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident’s needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme uses a framework to empower the residents to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities coordinator adapts activities to meet the needs and preference of choices of the residents.  The Activities Coordinator works Monday to Friday (30 hour week). The weekly activities plan sighted is developed based on the resident’s individual needs and interests and can be easily adapted and changed depending on the resident’s physical ability, interest and reaction at the time. Regular activities include daily newspaper reading and exercises, church services. All public holidays and special events are celebrated. For residents who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The care staff interviewed stated that they have access to activities to support residents after hours and on the weekends. Staff promote social interaction by inviting and encouraging all residents to join in activities together in the main lounge.  The residents’ files reviewed have activities and social assessments that identify the resident’s individual diversional, motivational and recreational requirements. Daily activities attendance sheet records are maintained for each resident and assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident’s file three monthly.  A challenging behaviour and assessment tool and monitoring form is developed for residents and care plans sighted evidenced interventions to support residents whom are presenting with challenging behaviours over a 24 hour period.  The outside environment provides easy access to outside garden areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.  All families interviewed stated that they were happy with the activities on offer and families and visitors felt included when they visited. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The residents’ files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.  Residents’ changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or is not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans were sighted for wound care, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans were documented in the residents’ progress notes. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover.  Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident’s condition. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | There is one GP who visits the residents at the facility and is available after hours via phone. The RN in discussion with the GP will arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident’s file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The GP interviewed reported that appropriate referrals to other health and disability services are well managed from the facility. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | The safe and appropriate storage and disposal of waste, infectious or hazardous substances is described in policy, as is storage and use of chemicals. The care and domestic staff interviewed demonstrated awareness of safety issues around managing waste and hazardous substances. Used continence products are disposed of appropriately. A spills kit is conveniently located for access when needed. The general manager stated that the service recycles and minimises waste as much as possible. Staff were observed on the days of audit to be using the readily available personal protective equipment. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Inspection of the interior and exterior of the building revealed that it is well maintained, in good repair and fit for purpose. The current building warrant of fitness is due to expire on 1 December 2016. All corridors, toilets and bathrooms have appropriately installed hand rails and there are disability accessible ramps outside. There is ready access to secure outdoor gardens and recreational areas. These areas are regularly inspected for slip hazards or other risks. There have been no incidents/accidents related to the external environment. The front door is keypad secure.  Improvements to the environment are ongoing. New lounge seating, furniture and beds have been purchased. Interior surfaces have been painted, art work areas of interest for residents are in place. Residents have been are assisted in identifying toilets by painting the doors in vivid colours with pictures that indicate their purpose and displaying directional signage to the toilet areas. A higher external fence was installed in March after a resident managed to climb over the previous one. The interior walls and skirting boards have been re-varnished.  There are no hoists on site. Electrical testing and tagging is completed by a certified electrician annually; records show this was completed in August 2015. All fire safety equipment is checked monthly by an external service agency. Calibrations of scales and medical equipment occurs annually and records show this occurred in June 2016. The health and safety officer and documents reviewed, confirmed that environmental inspections occur monthly and maintenance requests are attended to as soon as possible.  There is evidence that hazards are reported and the sighted hazard register is current and updated regularly. Visual inspection revealed that external areas are safe and meet the needs of the resident group. Seating is safe and suitable for older people and there is sufficient shade for sitting outdoors in the summer. .  The transportation of resident’s policy contains fully described and detailed information which is directly related to the safe transporting of residents |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | The home has an adequate number of easily accessible toilets and showers. For a maximum capacity of 25 residents there are two bathrooms, five toilets and seven hand basins. There are two designated staff and visitor toilets. Observations and staff interview confirm that resident privacy is assured by staff accompanying residents for ablutions and attending to their personal hygiene needs. Each toilet and shower room is clearly identified by different coloured doors, diagrams and directional arrows. Hot water areas accessed by residents is tested weekly to ensure it is delivered at a safe temperature. Water temperature records show no temperatures over 43 degrees. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | The 19 bedrooms are either single or double share. On the days of audit there are three shared bedrooms. This configuration is discussed with family and they sign their consent and agreement to room sharing. One family member interviewed confirmed their agreement and satisfaction with their relative sharing a bedroom. The rooms are of a generous size. The beds and bed are bed linen are being continually updated. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a separately designated area for dining which is used for recreation/art outside of meal times. The home is spacious with interesting internal walking areas for residents who were observed to be accessing other areas such as the second lounge. A range of activities are provided every day by the activities coordinator who is employed for 30 hours per week or the care staff on weekends. Activities of daily living, creative and physical play were observed to be maintaining resident’s interest on the days of audit. Residents are supported by staff to the dining room for all meals and tea breaks. The recreation and dining areas are safe for use by older confused people. The service has purchased new dining tables and chairs, occasional furniture, drapes and a large screen television since the previous audit. The atmosphere in the home on both days of audit was calm and settled. Family members described the environment as home like, quiet and peaceful |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry policies and procedures including job descriptions, and scheduled tasks are clearly described and known to staff.  Interviews with the cleaning and care staff demonstrate that efficient and effective systems are in place for cleaning and laundry. All areas in the home are observed to be kept clean and hygienic. Relatives expressed satisfaction with the cleanliness of the home and said they had no concerns or complaints about the care of residents’ personal clothing. This is carefully laundered and ironed by care staff on each shift. Staff attend regular education on safe use of chemicals and visual inspection of all areas of the facility reveal that chemicals are safely decanted into clearly labelled containers and are stored securely |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems are in place for essential, emergency and security services. Exit doors and windows are checked at dusk. Staff say any security incidents would be reported; there have been none.  Records sighted show that trial fire evacuations are occurring six monthly, most recently in May 2016. Fire suppression systems are checked monthly by an external service. The NZ Fire Services approved evacuation scheme was renewed in September 2012. Staff interviews and review of personnel files provides evidence of current training in emergency preparedness. Personnel files show that the two RNs and all care staff hold current first aid certificates. Emergency equipment is accessible, stored correctly, not expired, and is stocked to a level appropriate to the service setting. The facility has emergency lighting, stored torches, gas hobs and BBQ for cooking, extra food supplies, emergency water supply, blankets, and cell phones for use during power outages. Call bells are accessible/within easy reach, and are available in all resident areas including their bedrooms and ablution areas. Staff conduct regular checks of these.  Emergency and security systems meet the requirements of this standard and the aged residential care contract |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas have good natural light, safe ventilation, and effective underfloor heating. Family members interviewed stated the home is maintained at a safe and comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.  A RN is the infection control coordinator and is responsible for following the programme as defined in the infection control manual. Infections are monitored by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each staff meeting. If there is an infectious outbreak this is reported to staff, management and where required, to the DHB and public health departments.  The RN reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one to one, at shift handover and in resident’s documented progress notes.  A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The registered nurse has the role of infection prevention and control coordinator. Infection control issues are identified to staff. The facility has the support of a clinical infection control specialist nurse who is available for advice on infection prevention. Advice can also be sought from different external sources, including the laboratory diagnostic services and the GP. The infection control coordinator regularly attends infection control education. The registered nurse and caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, including managing sharps, managing multi-drug resistant organisms, exposure of blood and body fluids, personal protective equipment, single use items, outbreak management and pandemic policy, cleaning disinfecting and sterilisation, waste management policies, and policy related to staff sickness/infections. Staff were observed demonstrating safe and appropriate infection prevention and control practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The registered nurses and caregivers interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the registered nurse. Infection control in-service education sessions are held and family/visitor education is provided where appropriate. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents’ safety. The infection coordinator completes a monthly surveillance report. The service monitors wounds, urinary tract infections, respiratory tract infections, fungal skin, soft tissue, eye and gastroenteritis infections. Antibiotic use is also monitored and evidenced as discussed with the GP. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff, and where appropriate, resident meetings.  Infection rates for eye infections increased from zero to three in January 2016 and urinary and respiratory tract infections increased in June of 2015. Care planning and intervention/evaluation and minutes of meetings showed how staff were reducing and minimising risk and trends and actions to take to reduce the spread of infections for individual residents and as a facility. Documentation and rationale was evidenced to show that residents whom had eye infections were unrelated in incidence. All residents unwell were assessed as being at the appropriate level of care. An external contractor benchmarks and surveys the facilities data for respiratory and urinary tract infections and falls. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service policy on restraint contains definitions and information which is congruent with the requirements of this standard. Processes for assessment, approval and consent, monitoring and review, evaluation, cultural considerations, de-escalation and staff training are clearly described. Kintala also has a well described policy on understanding and managing challenging/difficult behaviour in relation to dementia. The contents of the restraint register since it was established, shows that use of restraint interventions is minimized and only used for safety reasons when absolutely necessary  The restraints approved for use are bed rails and a safe seat. On the days of audit, two residents are listed in the restraint register as requiring use of the safe seat to prevent falls. There were no enablers in use. Review of the two residents’ records revealed that processes are adhered to and interview with the restraint coordinator demonstrated a thorough knowledge and understanding of the requirements related to restraint. Staff understanding is tested by the completion of questionnaires at least bi-annually. Information on the provider’s philosophy of restraint minimisation and management of challenging behaviour occurs at orientation. Ongoing education is mandatory for all staff to attend annually. Services are provided in a discreetly secure locked environment which is appropriate and necessary for resident safety. Residents have access to external gardens which are secure and safe. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The processes and agreements required for approval are clearly described and adhered to. Responsibility for restraint coordination is delegated to the restraint coordinator who is a registered nurse. The coordinator’s role and accountability is documented. Documents sighted and staff interviews show that approval for restraint is always based on the initial assessment for restraint use. The decision to seek approval is made by the restraint coordinator with input from care staff and the other RN, the resident’s GP, and the resident’s family. Approval for ongoing restraint needs is reviewed every three months or earlier if indicated. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Each resident is assessed on admission and at regular intervals to ensure the parameters around restraint use are clearly identified. The two residents’ records reviewed showed that alternatives to restraint interventions are considered, the circumstances that indicate restraint use are appropriate and the safety of the resident is taken into account. The assessments reviewed had been undertaken by the restraint coordinator with input from other RNs and carers. The assessment includes identification details of the resident, the potential effects of restraint use on the resident and their family/whanau, the risks associated with the use of the particular form of restraint and the management and evaluation of those risks, any events in the resident’s life that may have an influence on their care or behaviour (eg, trauma or abuse), general needs of the resident, and specific cultural needs (where applicable) and how these would be best met. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The resident records have signed copies of the individual assessment, restraint alternatives and informed consent record and an individual restraint minimisation care plan. These contain details about the frequency of monitoring and review and the degree of risk identified for each resident. Observation of one resident in a safe seat showed this was discreetly applied and regularly taken off. Interview with a family member of the other resident who uses the safe seat reveals that alternatives have been tried, risks around the use of the restraint intervention have been discussed and the effectiveness of the intervention continues to be reviewed. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The effectiveness and ongoing need for restraint interventions is evaluated and reviewed with appropriate frequency. Records show a detailed three monthly evaluation of the effects of the restraint intervention, summary of the monitoring records and evaluation and changes to the restraint care plan. The family member interviewed stated they continue to feel consulted and informed about why and when the safe seat is used. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The annual quality review of restraint occurred in January. Records sighted and staff interviews showed that this included a review of policies and procedures, a summary of the extent and types of restraint in use, the ways that restraint is actively minimised, checking adherence to monitoring and review protocols and consideration of the restraint education programme |

# Specific results for criterion where corrective actions are required

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

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

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

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| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | CI | A need to improve night staff attendance at staff education sessions was identified in 2015. Interviews with the GM and the RNs and review of the project plan show discussion about various methods to increase attendance. The night staff were consulted and arrangements were made for the evening RN to provide one to one coaching and support along with reminders to attend upcoming sessions. Review of four night staff files showed their average attendance at monthly in-service education for 2013 to 2015 was two sessions per annum. So far this year the same night staff have attended six sessions. | A quality improvement project aimed at increasing the frequency of night staff attending monthly in-service sessions has resulted in a measurable improvement. Night staff are now regularly attending these sessions and are reported to be fully engaged and succeeding with competency and skills testing. |

End of the report.