

Maniototo Health Services Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Maniototo Health Services Limited
Premises audited:	Maniototo Health Services
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 September 2016 End date: 9 September 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:	29

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Maniototo Health Services Limited has an inpatient unit for acute medical care, a wing for residents/patients requiring hospital level care and a separate building adjacent to the hospital for residents/patients requiring rest home level care. The service is based in Ranfurly.

The service provides care for inpatient services including general medicine, palliative care, rehabilitation including hospital level aged residential care and rest home level of care. This surveillance audit has been carried out to establish compliance with a subset of the relevant Health and Disability Services Standards and the district health board contract.

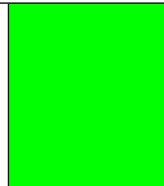
The day to day oversight of the hospital is provided by a general manager, who is supported by a clinical nurse manager and nurse manager in the rest home. The service had 29 residents/patients at the facility at the time of the audit.

There are two areas requiring improvement relating to the incident and accident records to be more specific and staff records.

All previous requirements for improvement were closed out. Documentation to confirm that family have been notified of incidents and accidents was sighted. Consents are documented for treatment, information sharing, transportation photographs and outings; review of trends showing outcomes and how it is used to improve services. Corrective actions show evidence of resolution and staff have signed employment contracts on file. Previous requirements for improvement also closed out relate to clinical services including handover; risk assessments for care planning; review of activity plans; medicines stock reviews; self-administering of medicines; and restraint assessments.

Consumer rights

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



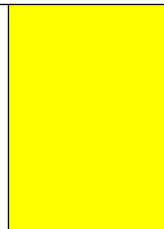
Standards applicable to this service fully attained.

Staff demonstrated an understanding of their obligations relating to information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Residents/patients, and where appropriate their family, are provided with information to assist them to make informed choices.

The residents'/patients' cultural, spiritual and individual values and beliefs are assessed on admission. The service had a complaints process that meets legislative requirements. A complaints register was documented showing evidence of follow up of 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.



Some standards applicable to this service partially attained and of low risk.

The service has a documented quality and risk management system. Policies were reviewed and quality and risk performance is reported through regular meetings.

There is an ongoing core training programme that is documented and implemented. Each employee has evidence of recruitment and ongoing performance appraisals. Staff files evidence employment contracts.

The strategic/business plan and quality and risk plan are reviewed. Quality risk management systems ensure resolution of issues when identified, including analysis of trends to improve quality of service.

Continuum of service delivery

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

The process for planning, provision of care, evaluation and review of care and exit from service are provided within timeframes that safely meet the needs of long-term residents/patients and those residents/patients in the acute care setting. InterRAI assessments are performed on admission to the service and reviewed six monthly.

The services are coordinated in a manner that promotes continuity in service delivery and team approach to care delivery. Written and verbal handovers are provided between all shifts and for the medical staff rounds performed daily.

The care plans in the rest home, hospital and acute care ward describe the needs, risks and interventions required for each individual resident/patient. Where progress was different to that expected, the service responded by initiating changes to the care plan or with the use of short-term care plans.

Activities are provided in the rest home and hospital. The activities are both planned and spontaneous, and provided to develop and maintain skills and interests that are meaningful to the resident. The activity plan reviews are completed six monthly or sooner if the condition of the resident changes.

There are processes in place for a safe medicine management system. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage. No residents/patients are self-administering medicines. The service has a contracted service provider. Residents/patients were satisfied with the meal service.

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.
--	--	--

The service holds a current building warrant of fitness. Residents/patients and family interviewed described the environment as appropriate, with indoor and outdoor areas that meet their needs.

Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures reflect current good practice and meet legislative and Health and Disability Services Standard requirements. Staff education related to restraint minimisation occurs during orientation and is included in the annual education plan to minimise restraint/enabler use. Restraint assessments now include restraint risk. No enablers are in use.

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.

Surveillance for infections is undertaken monthly. Results of surveillance are analysed to assist in achieving infection reduction. The infection surveillance results are reported to staff and management in a timely manner. The provider did not report having had any outbreak of infection since the previous audit.

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	18	0	2	0	0	0
Criteria	0	44	0	2	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](#).

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 1.1.10: 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>	<p>FA</p>	<p>There is an informed consent policy and procedure to guide staff in the care of residents/patients. Staff complete training on consent as part of orientation and induction to the service (refer 1.2.7.4). The admission form provides opportunity for each patient to sign a health information statement consenting to the service collecting and sharing information and consent is obtained on admission. Consent includes consent for procedures and consent to information sharing, the use of photographs, treatment and transport.</p> <p>Advance directive policy and the 'do not resuscitate' orders (DNR) are in place. Residents/patients make informed decisions relating to DNR orders. Policies confirm their practices.</p> <p>The previous requirement for improvement relating to consent having to be documented for treatment, information sharing, transportation and use of photographs was implemented.</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>	<p>FA</p>	<p>The complaints policy reflects the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes timeframes for responding to a complaint. Complaint forms are available at the entrances to the hospital with the opportunity to make an</p>

		<p>anonymous complaint. A complaints register is in place and includes: the date the complaint is received; the source of the complaint; a description of the complaint; the actions implemented and the outcome of the complaint as well as the date the complaint is resolved. The complaints register covered complaints since 2008 and showed that there have been no complaints since August 2014.</p> <p>Complaints reviewed indicated that complaints are investigated promptly with the issues resolved in a timely manner, at the time of the complaint. The general manager with the support of the clinical nurse manager is responsible for managing complaints. Residents/patients and family stated that complaints are dealt with as soon as they are identified.</p> <p>There has been one complaint lodged with the Southern District Health Board (SDHB) since the certification audit and the provider has been informed telephonically of this complaint but has not yet received any documentation relating to the complaint in order to investigate or follow-up on the complaint. The general manager confirmed that there have been no other complaints or investigations with external authorities since the previous audit.</p> <p>Staff interviewed verified they advise residents/patients and family of the Code and its content including the complaints process. Meeting minutes confirmed complaints being part of a set template on the meeting agenda.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The service has a policy on open disclosure to guide service provision. Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family and/or the enduring power of attorney of accidents and incidents. Family are informed when the resident/patient has an incident, accident or has a change in their health needs. Resident/patient records were integrated. Residents/patients and family members confirmed that open disclosure occurs. Family contact is recorded in resident/patient progress notes.</p> <p>Interpreter services are offered to residents/patients and their family where needed. The service has an interpreter register with specific people in the community available to provide interpreter services when needed. Family members may be the first choice as interpreter if the residents/patients prefer. The service has staff members available to assist in interpreting services where possible. There were no residents/patients requiring interpreter services during the audit.</p>

		The previous requirement for improvement relating to documentation having to be completed confirming that family are notified in a timely manner after incidents or accidents was implemented.
<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 board provides a governance role with trustees who meet monthly. The service has a clear mission and values documented. The board works with the management team and staff to provide strategic direction. Monthly reports from the general manager (GM) to the board ensure the board is being informed of operational matters. The GM has accountant and management experience in the rural area, and has been in the role for more than eight years.</p> <p>There is a strategic/business plan that is developed by the board and the GM. The quality and risk plan is a rolling plan that was reviewed for 2015/16. There is a quarterly review process for management where the risk/strategy/improvement plans are updated.</p> <p>Maniototo Health Services Ltd (MHSL) has a management team that includes the GM, the clinical nurse manager and the nurse manager from the rest home. There is medical leadership from the general practitioner who is on site and on call during the week. There is a locum when the general practitioner is on leave to provide medical leadership and also includes the Primary Response in Medical Emergency (PRIME) nurses.</p> <p>There are 31 beds, 16 in the rest home and 15 dual purpose beds for hospital (long-term care) and acute inpatient care. Occupancy on the day of the audit was 29 with 4 identified as requiring inpatient care, 9 requiring hospital care and 16 in the rest home area.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality and risk management policy provides a framework for the implementation of the risk management programme which guides processes to identify, assess, prioritise, manage and monitor risk relevant to the organisation. Policies are reviewed, current and up to date. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, and implementation of an internal audit programme. Incident and accident records are completed however there is not consistent evidence of corrective actions being identified, the person responsible for the implementation of corrective actions being identified or</p>

		<p>timeframes for implementation being recorded (refer 1.2.4.3).</p> <p>Incidents, accidents, near misses, complaints, adverse events, infections, restraints or enablers, and health and safety issues are graphed and reported monthly to the quality management team, and to each area, as appropriate. Staff interviewed could clearly demonstrate the process for reporting adverse events.</p> <p>Monthly meetings include quality management (including health and safety), general staff, and registered and enrolled nurses, which ensure that there is communication with all staff regarding aspects of quality improvement and risk management. Staff reported that they are kept informed of quality improvements.</p> <p>The satisfaction survey for family and residents/patients in 2016 shows that they are satisfied with services provided and this was confirmed during patient and family interviews. The previous requirements for improvement relating to trends to be reviewed, analysed and used for improvement of services and corrective action evidence show resolution of issues are implemented.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>The general manager and the clinical nurse manager were aware of situations in which the service would need to report and notify statutory authorities including: police attending the hospital; unexpected deaths; sentinel events; notification of a pressure injury; changes in key clinical managers and infectious disease outbreaks. An incident where a fracture was sustained was not recorded as a section 31 report to the Ministry of Health (MoH) and this was implemented on the day of the audit. Subsequent to the audit requirements to report fractures in a section 31 have been removed.</p> <p>The incident recording, reporting and investigation policy was sighted. The service implemented a system to analyse and monitor incident and accidents at management level, however the incident/accident investigation records do not consistently evidence the corrective actions, the person responsible or the timeframes for implementation of corrective actions (refer to 1.2.4.3).</p> <p>Staffs receive education as part of the ongoing training programme on the incident and accident reporting process. Staff understood elements of the adverse event reporting process and are able to describe the importance of recording near misses.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>Staff files include recruitment documentation including: signed contracts; job descriptions; reference checks and interview records. There is an appraisal process in place and staff files reviewed had current performance appraisals completed. Not all staff files evidenced completed orientation or induction programmes; this is a requirement for improvement. Staff files demonstrate competency on a number of areas of care and intervention and interviews confirmed a low turnover of staff.</p> <p>There is annual, ongoing, professional development for staff. The organisation has an education and training programme with an annual training schedule documented. The clinical staff confirmed opportunities for external professional development and staff complete emergency level training, including resuscitation.</p> <p>Annual medication competencies were completed by staff who administer medicines to residents/patients. Education and training hours exceeded eight hours a year for registered nurses and all other staff relevant to their roles.</p> <p>The service has three registered nurses who have completed InterRAI training.</p> <p>The previous requirement for improvement relating to staff not all having signed contracts on file was implemented.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy guides workforce planning. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents/patients. Rosters reflected staffing levels meet patient acuity and bed occupancy. Staff are replaced when on leave and this is documented in rosters reviewed.</p> <p>The clinical nurse manager and the general practitioner provide clinical oversight of the service. The general practitioner also has a private medical practice on site with locums and Primary Response in Medical Emergencies (PRIME) nurses providing cover.</p> <p>Residents/patients, family members and staff confirm that staffing is adequate to meet the residents'/patients' needs.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p>	<p>FA</p>	<p>The medications for the rest home and long-term hospital residents/patients are supplied by the contracted pharmacist in a pre-packed administration system. The pre-packed medicines and the signing sheets are compared</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>against the medicine prescriptions when delivered monthly and when administered. The GP conducts a medicine reconciliation on admission to the service and when the resident has had any changes made by other specialists. Safe medicine administration was observed at the time of the audit.</p> <p>Controlled drugs are managed in the hospital to meet legislative and aged care guidelines. The controlled drugs are checked weekly by the pharmacist and a registered nurse. There are no controlled drugs stored at the rest home. The medicine trollies are locked when not in use.</p> <p>Medication competencies were sighted for all staff who assist with medicine management. Competencies are completed annually. Medication records were randomly selected and reviewed. The GP locum uses a stamp with full name and registration number recorded. Signature signing sheets were available and all allergies and sensitivities were documented and stickers used as required as an alert.</p> <p>There were no residents/patients who were currently self-administering medications. Processes are in place should a resident/patient be authorised to administer their own medicines by the GP. There were two previous improvements from the previous audit and they are closed off.</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>Three cooks are employed to cover the food service weekly. The food service is contracted out to a private service provider. All staff who work in the kitchen have completed food safety and hand hygiene infection control education and this was evidenced in the education records and personal staff records reviewed.</p> <p>Food is received in large chiller boxes, and is then heated and prepared by staff. A hot box is used to transport food to the hospital and rest home and is then served from the kitchen facilities in both areas of the service by staff. The menu plans summer/winter are reviewed by the service provider dietitian. Spare meals, fresh fruit, baking and other foods are available for any acute admissions or for long-term residents/patients if needed. Morning, afternoon tea and supper is provided. Residents/patients and family/whānau reported satisfaction with the meals and fluids provided.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences</p>	<p>FA</p>	<p>Staff interviewed confirm access and entry processes are followed. A multidisciplinary approach to assessment is evident in the files reviewed. This included a medical review by the GP and a family support assessment by the</p>

<p>are gathered and recorded in a timely manner.</p>		<p>social worker. Resident/patient summaries outline personal information, contacts, service providers, medical information, environmental, past medical history current medications and a current care plan summary. Residents'/patients' needs, outcomes and goals are identified and recorded. Residents'/patients' files reviewed demonstrate full and comprehensive nursing and medical assessments for the level and types of care required. Appropriate resources and equipment are available. Risk assessments are now consistently completed to ensure care plans are specific and current. This was a previous improvement which has been closed out.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The residents/patients and family/whānau reported that the staff have good knowledge and care skills. The GP locum interviewed expressed satisfaction with the care provided. The provision of services and interventions were clearly documented for the residents/patients in both the rest home and the hospital. The care plans were individualised and personalised to meet the specific assessed needs of each resident. The care was flexible and focused on promoting quality of life for the long-term residents/patients and residents/patients in the acute service. Residents/patients and family/whānau reported satisfaction with the care and service delivery.</p>
<p>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.</p>	<p>FA</p>	<p>The activities coordinator is currently undertaking Careerforce activities coordinator training. There are planned and spontaneous activities provided. A monthly programme is developed and a daily activities programme is displayed. Resident meetings have been developed and implemented for rest home, hospital and acute care residents/patients to attend six monthly. Minutes of the first meeting were sighted. The activities plans for the long-term residents/patients are reviewed and signed off by the activities coordinator and a New Zealand Registered Occupational Therapist (NZROT) six monthly. This was an improvement from the previous audit which has been effectively closed out. The service has links with other community organisations, churches and local schools. Hospital residents/patients and rest home long-term residents/patients, as able, join together for activities such as music and entertainment sessions.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluations are planned to be conducted six monthly for the long-term rest home and hospital level care residents/patients. For acute care residents/patients evaluations occurred at each point of contact. The progress records are updated regularly. There is evidence that the care is evaluated also</p>

		<p>when there has been a change in the resident's/patient's condition. The short-term care plans evidenced interventions are evaluated more often. The GP locum interviewed reported that the registered nurses make contact in a professional manner. After hours services are available.</p> <p>Where progress was different from expected, the service responded by initiating changes to the care plan or by use of short-term care plans for temporary changes. The residents/patients and family reported satisfaction with the care provided in each area of the service.</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>The service has a current building warrant of fitness that is displayed in a prominent location. There have been no building modifications since the last audit.</p> <p>Interviews with staff confirmed there is adequate and appropriate equipment. There are quiet areas throughout the facility for patient and visitors to meet including a resident/patient and family lounge in both the rest home and the hospital/inpatient areas. There are safe external areas that are easy for residents/patients and family members to access. The service provides access to public parking facilities that includes disabled parks. Rails and ramps are appropriately placed to provide support for residents/patients.</p> <p>There is an ambulance entrance in both the inpatient/hospital area and in the rest home area.</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 conducts monthly surveillance for infections. The service uses standardised definitions of infections that are appropriate to this long-term care facility and acute care setting. The surveillance data inclusive of laboratory services infection sensitivities results, is analysed, reviewed, trended and results are reported back to all staff at the staff meetings. Infection surveillance/analysis and trends 2016 are maintained by the clinical manager electronically. The analysis records the reason for any increases and any actions that may have been implemented to reduce reoccurrence.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint is minimised at Maniototo Health Services. Enablers are used to assist residents/patients to maintain independence. No enablers are currently in use.</p> <p>Staff interviewed are aware of the difference between an enabler and a restraint and what actions need to be taken related for the use of both.</p>

		Restraint minimisation is included in staff orientation/induction processes. Ongoing education is provided and is documented on the staff education calendar sighted.
<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>	FA	The restraint/enabler process is clearly defined and there are clear lines of accountability for restraint use. The assessment records now include any identified restraint risks. This was an improvement from the previous audit that has now been closed off.
<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>	FA	Policy identifies that an enabler is voluntary and the least restrictive option to keep the resident safe. All documentation completed complies with policy and legislative requirements.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	Incident and accidents are identified and recorded on reporting forms. Incidents and accidents are analysed and trends identified. Not all incident and accident records identify corrective actions or the person responsible for the implementation of the corrective actions with timeframes for implementation.	<p>i) 3 of 10 incident/accident records reviewed did not clearly identify corrective actions.</p> <p>ii) 6 of 10 incident/accident records reviewed did not identify the person responsible for the implementation of the corrective actions.</p> <p>iii) 6 of 10 incident/accident records reviewed did not identify the timeframes for implementation of corrective actions.</p>	<p>i) All incident/accident records to clearly identify the corrective actions.</p> <p>ii) All incident/accident records to identify the person responsible for the implementation of corrective actions.</p> <p>iii) All incident/accident records to identify the timeframes for implementation of corrective actions.</p> <p>180 days</p>
Criterion 1.2.7.4	PA Low	Nine staff records were reviewed during the	i) Five out of nine staff folders	i) All staff files to show

<p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>		<p>audit. Review of the staff records included reference checks, a signed contract, job descriptions, police checks for newly appointed staff, copies of qualifications, evidence of training, practice certificates, where required; performance reviews, confidentiality agreements and evidence of induction and orientation. Information contained within staff files/records was disorganised and filed in an unstructured manner.</p>	<p>reviewed did not have evidence of orientation/induction having taken place for the individuals.</p> <p>ii) Information contained within staff files/records is disorganised resulting in difficulty ascertaining whether all information required is present.</p>	<p>evidence of orientation/induction having been provided.</p> <p>ii) Information contained within staff files/records is filed in an organised manner.</p> <p>180 days</p>
---	--	---	--	---

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.