# Aria Gardens 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 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:** Aria Gardens Limited

**Premises audited:** Aria Gardens Home and Hospital

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

**Dates of audit:** Start date: 8 December 2016 End date: 9 December 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:** 151

# 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** |
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|  | 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

Aria Gardens Home and Hospital is owned by Arvida Group one of the larger operators of aged care facilities in New Zealand. The service provides rest home, hospital and dementia services for up to 153 residents.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider`s contract with the district health board. The audit process included the review of organisational documentation, staff records and residents’ clinical records, observations, and interviews with residents, families/whanau, management, staff and a general practitioner. The General Manager Wellness and Care was present for one day of the audit.

Feedback from residents and families/whanau members was positive about the care and service provided.

There were no corrective actions to follow up from the previous audit. One area was identified for improvement at this audit, in relation to interRAI assessments.

## 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. |

Residents and family/whanau receive full and frank information which reflects the principles of the open disclosure policy. The resident and their family/whanau are involved in the care planning, decision making and consent processes. Where there is a valid advance directive, the staff act on the decisions. Interpreter and translation services are available if required.

The service has a documented complaints management system implemented. There are no outstanding complaints at the time of this audit.

## 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. |

The facility manager is responsible for implementing the organisation`s business and strategic plan 2016. The plan covers all aspects of service delivery and is reviewed annually. Quality data covers all key components of service delivery and is collected, reported and analysed monthly. Results are shared at all levels of the organisation and corrective action planning is put in place where areas of concern or deficits are found. This allows effective, timely service delivery.

The quality management systems include an internal audit process, complaints management, incident/accident/near miss reporting, annual resident surveys, staff surveys, restraint monitoring, and infection prevention and control data collection. Quality and risk management activities and results are shared with management, staff, residents and family/whanau as appropriate.

The facility manager is responsible for the day to day management of the service. The facility manager has a support team of two clinical managers, a team of registered nurses and educated caregivers. Education is provided for all staff and an annual programme is available.

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

The service is coordinated in a manner that promotes continuity in service delivery using a team approach to care delivery. The service uses a mix of electronic interRAI and paper based assessment tools. Interventions are documented to show how to achieve the resident’s desired outcomes and goals. Long and short term care plans are developed and implemented in a timely manner. Care plans reflect the assessed needs of the resident and are evaluated at least six monthly, or sooner if there is a change in needs. Interventions are sufficiently detailed to address the desired goals/outcomes.

Activities are planned and provided as appropriate to the needs, age and culture of the residents. This allows the skills and interests of residents to be maintained.

The medicine management system in place meets the required regulations and guidelines. Safe medication management procedures were observed on the days of audit in all three service areas (dementia, rest home and hospital). Staff who administer medication hold current medication competencies which reflect current good practice.

The resident’s nutritional requirements are met by the service and residents’ preferences and special diets can be catered for. Kitchen staff attend safe food management education. Meals are prepared from a menu approved for aged care by a registered dietitian.

## Safe and appropriate environment

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

The facility undertakes process to ensure the building warrant of fitness is kept up to date.

## 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. |

Policy states that enablers shall be voluntary and the least restrictive option to safely manage the needs of the resident. At the time of audit there are eight enablers and 27 restraints in use. Staff undertake education related to restraint minimisation and they have a clear understanding of the difference between enablers and restraints and how to safely manage both.

## 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 infection prevention and control management programme, inclusive of surveillance, is appropriate for the nature of the service. The infection control coordinator is a registered nurse. Monthly surveillance data is collated and findings are reported at staff, management and organisational level. Corrective actions are put in place if an upward trend is identified. Benchmarking occurs against 26 other organisational groups as well as by an outside contracted company.

## Summary of attainment

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

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| **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 | 15 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 1 | 0 | 0 | 0 |

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| **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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Aria Gardens Home and Hospital implements the organisation’s policies and procedures to ensure complaints processes reflect a fair system. During interview, residents, family/whanau and staff reported their understanding of the complaints process. Staff confirmed they document verbalised and written complaints so that all issues are accurately reflected and followed up by the facility manager.  All complaints are investigated by the facility manager and documentation is contained in a register reviewed which identifies the nature of the complaint, the dates received and the actions taken to address the complaint. Documented complaints information is use to improve services as appropriate. Complaints information is shared at staff meetings and with the Arvida Group directors as required. This is confirmed in the monthly reports completed by the facility manager and sent to head office, and meeting minutes sighted and during staff and management interviews. All complaints are accurately recorded.  Complaints forms are available to residents and visitors.  There were no outstanding complaints at the time of audit. One external complaint made to the Health and Disability Commissioner (HDC) (lodged 7 July 2016) was effectively closed out 25 November 2016. A copy of the outcome of this complaint was sent by the HDC to the DHB as funder of the rest home and to HealthCERT at the Ministry of Health. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Staff and management confirm residents` rights to full and frank information. The service implements the open disclosure policy. Family/whanau contact is documented in the residents’ files. Family/whanau stated they were kept well informed about any changes to their relative`s health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. There was also evidence of resident/family input into the care planning process.  At the time of audit there are some residents with English as a second language. The service has processes in place to ensure the resident is able to communicate their needs and understand what staff are asking. Interpreter services are available through the district health board and national interpreter service information is available if required. Staff are aware of how to contact approved interpreter services and stated they would use policy guidelines as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Aria Gardens Home and Hospital is owned by the Arvida Group. The organisation has a business plan which is reviewed annually. The plan was dated in April 2016. The business plan is monitored monthly by management to measure progress towards meeting goals. The Arvida Group vision, mission and values are clearly documented which guide service provision with the aim of ensuring planned, coordinated service delivery to meet the needs of the residents.  On the day of the audit, the service had 151 residents; 20 dementia level care, 43 rest home level care and 89 hospital level care.  There is a facility manager in place who has extensive business management experience and has been in this role since March 2016. The facility manager is supported by two clinical managers and a team of registered nurses. The facility manager, who is not experienced in aged care, has attended aged care leadership and health management study days since the appointment. The two clinical managers each have annual practising certificates and undertake appropriate ongoing education for the clinical role they perform. The general wellness and care manager for the organisation was present for the first day of the audit.  Accountability and responsibilities are clearly described in the job descriptions sighted. |
| 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 | Aria Gardens Rest Home and Hospital has a quality and risk management system which is understood and implemented by service providers. This includes the update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and management, and restraint management. If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective action plans are developed and overseen by the facility manager. Quality related information is shared with all staff via the handover process on each shift and/or during the staff meetings. This is verified during staff interviews and in documentation sighted. Reporting is undertaken electronically by the clinical managers; one for the hospital and one who is responsible for the rest home and the dementia unit. Both clinical managers report to the facility manager on a monthly basis.  The policies and procedures reflect legislative and good practice requirements. There is a system in place at head office to ensure they are kept up to date. The service is in transition with policies and procedures being updated and reviewed to meet Arvida Care & Wellbeing protocols and procedures.  Quality data is trended against previously collated data. An annual review occurs at management level within the facility and input sought from the Arvida support office as appropriate. This is linked to the quality and risk management system and is used to highlight both positive and negative findings. Day to day analysis of data is monitored by the facility manager and reported monthly. Benchmarking occurs with other aged care services in the organisation.  Staff, resident and family/whanau interviews confirmed any concerns they have are addressed by management. Staff gave examples of quality improvements made since the new service providers have owned this facility.  Actual and potential risks are identified using the quality and risk planning processes. Any newly identified hazards are discussed, monitored and managed via the health and safety processes in place. The facility manager oversees this process. Staff confirmed that they understand the implemented hazard identification processes. The hazard register reviewed is current and up-to-date. |
| 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 | Adverse event reporting, as identified in policy, is implemented by the service. The facility manager confirmed the awareness of the organisation`s requirement related to statutory and/or regulatory obligations including the need to report pressure injuries under section 31 of the Health and Disability Services( Safety) Act 2015. Reporting forms are included in the policy manual reviewed. Confirmation related to reporting of an infection control outbreak this year was reviewed.  Staff interviewed stated that they report and record all incidents and accidents and that this information, along with any corrective action requests, is shared at the staff meetings. This was confirmed in minutes of meetings sighted.  Residents’ records reviewed included any incident and accident forms. The forms sighted identified that all issues reported had corrective actions in place when required. Information is entered electronically and the facility manager monitors corrective actions and documents any outcomes. The general manager wellness and care interviewed would be notified by the facility manager of any serious adverse event that occurs. Family/whanau notification is clearly written in documentation and confirmed during family/whanau interviews.  Management interviewed reported that information gathered from an incident and/or accident is used as an opportunity to improve services as required or indicated. |
| 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 | Human resources management processes are conducted in accordance with good employment practices and meet legislative requirements. The service appoints appropriate service providers to meet the needs of the residents. Processes are clearly identified in the policies and procedures sighted.  Staff records show that all roles have job descriptions that describe staff responsibilities and accountabilities. Staff complete an induction handbook along with specific competencies for their roles and covers all essential components of service provided. The orientation/induction process is completed for all new staff. Documentation in the staff records reviewed confirmed some competencies, such as medication management, restraint and infection control, are reviewed annually.  Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. There is a system in place to ensure these records are verified annually by the clinical managers. Employment processes included reference checking, police checks, and annual staff appraisals. A checklist was observed in each individual staff record. All appraisals were up to date in the staff records reviewed. A registered nurse has recently completed the training as a Careerforce assessor. The core care staff had all completed aged care qualifications inclusive of advanced dementia and eight care staff are enrolled in the Careerforce training programme being implemented in 2017, to complete dementia training offered. Seven registered nurses hold current interRAI competencies.  The education programme sighted for 2016 identifies that staff undertake training and education related to the roles they undertake. Topics covered in the annual training and education relate to aged care and health care services. Members of the management team also attend training and seminars specific to management related topics. Education occurs both on and off site.  Residents and family/whanau members interviewed, identified that the service meets residents` needs. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented process in policy which determines service staffing levels and skill mix for the three services provided. The two clinical managers interviewed confirmed the rostered numbers of staff change according to residents’ needs. Staff numbers sighted on four weeks of rosters showed that core staffing is maintained to meet residents` needs and to comply with contractual requirements.  Rosters identify that staff are replaced for sickness, study and annual leave. This was confirmed during interviews with staff and management. Staff reported they had adequate time to complete the required tasks to meet residents’ needs. There are registered nurses on duty for all shifts. There is an on-call system for clinical advice and support after-hours. The general practitioner interviewed covers the after-hours for this facility.  Resident and family/whanau members interviewed stated all their needs have been met in a timely manner. |
| 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 observed medication procedures are implemented to meet legislative and best practice requirements. Each of the three areas (dementia unit, rest home and hospital) store medications in a secure area. Medications that require refrigeration are stored in a medication fridge, with the temperatures monitored daily. The processes for controlled drug management meet requirements.  The medications are delivered by the pharmacy in a pre-packed administration system. These medication packs and the signing sheets are checked for accuracy upon delivery. The medication charts and prescriptions have the required information hand written by the GP. Medication is signed by the GP upon prescribing, showing the dates, time and route required. The medication reviews are recorded on the resident’s medication chart and are undertaken at least three monthly. As the GP is on site at least two days a week, required changes to medication is often more frequent.  The staff members observed undertaking a medication round followed safe medication procedures. Staff verbalised their knowledge related to the use of stock and pro re nata (PRN) medication. The caregivers who are medication competent in the rest home and dementia care areas can only administer pre-pack medication. If the resident has medications that are not pre-packed, such as warfarin or antibiotics, they must be checked with a registered nurse. In the hospital wings, only RNs administer medications. All staff who administer medications are assessed as competent to do so by means of an annual update programme.  There are no residents who self-administer their medications at the time of audit. Staff stated if this were to occur, policy and procedures would be followed to ensure the resident was competent to self-administer safely.  Medication audits are conducted six monthly with appropriate follow up shown. This was last conducted in September 2016.  If a medication change is made by the GP family/whanau are notified, the reason for the change is explained to the resident and family/whanau and it is documented in the resident’s notes and discussed at handover. This was confirmed during interviews undertaken. |
| 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 | Food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. All meals are prepared and cooked onsite. Staff who work in the kitchen have food handling certificates. A kitchen cleaning schedule is in place. The menu has been approved by a registered dietitian (May 2012) as being suitable for aged care. At the time of audit the menu was undergoing a review process as confirmed in documentation sighted and discussed with the facility manager and support services manager.  Residents are provided with meals that meet their food, fluids and nutritional needs. Dietary requirement forms are completed on admission by a registered nurse and the cook is informed of any additional or modified foods that may be required. This information, including residents’ dislikes, are shown on a white board in the kitchen. The cook stated all residents’ needs can be met by the service. This was supported during resident interviews when they reported the food is excellent and they are given alternatives if they do not like what is on the menu.  It was observed that the kitchen flooring outside of the chiller is in need of repair. The service has this shown on the maintenance to be undertaken form and head office are aware of the need for kitchen flooring replacement. The support services manager confirmed a capital expenditure note has been submitted to undertake this work.  All residents are weighed monthly and weight changes are managed appropriately by 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 | Support and care is individualised and focused on achieving desired outcomes/goals set. The service uses both long and short term care plans as appropriate. The documented interventions are consistently recorded to a level of detail that provides clear strategies for each individual resident. The care plans and interventions are based on the outcomes from the assessments and the identified needs of the resident. The care plan format includes the resident’s specific needs, goals/aims and staff interventions required to address those needs. There is a specific family/whanau contact form in each file reviewed which shows that they are informed of any concerns staff may have regarding their relative.  Care was observed to be flexible and focused on promoting quality of life for the residents. The residents and family/whanau interviewed reported a high level of satisfaction with the care and with specific management to meet their needs.  Members of the management team and all other staff interviewed demonstrated appropriate skills and knowledge of the individual needs of all residents. |
| 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 residents are included in meaningful activities in all service areas of the facility. The activities programme covers physical, social, recreational and emotional needs of the residents. The activities coordinators document planned activities, resident attendance and evaluation of the activities undertaken. The activities coordinators reported that they gauge the response of residents during activities and planning is modified related to the response and interest shown. Residents engage in community activities as they wish and family/whanau are encouraged to be involved in activities as they are able. There is weekly entertainment at the facility along with visiting church and school groups.  The facility manager stated that activities are being reviewed on a daily basis and projected 2017 planning was sighted. An activities coordinator works in each service, for example, hospital, rest home and dementia care, five days a week with Saturday activities being introduced two weeks prior to audit.  The residents and family/whanau reported overall satisfaction with the level and variety of activities provided. One family/whanau member whose relative is in the dementia care unit stated that there is always an activity occurring including outings that their relative attends. Activities were witnessed in all areas, including a musician in the dementia unit, with all residents from the facility invited. There was a large attendance at the performance. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluations are conducted at least six monthly and clearly recorded on the resident’s care plan. This involves a multidisciplinary team meeting including the GP and family/whanau. These meetings identify the degree of achievement or response by the resident to the interventions put in place. When there are changes in the resident’s needs, the service uses a short-term care plan to capture changes that are not likely to be ongoing. If the change is ongoing, the long-term care plans are updated.  Residents and family/whanau confirmed their attendance at meetings and input into care planning evaluation and updates. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes are undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 20 July 2017. There is an approved New Zealand Fire Service evacuation plan which was approved 14 January 2014. Fire drills are held for staff six monthly and the last drill was 14 September 2016. Three training sessions were held and 120 staff attended. |
| 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 | The service implements policy and procedures as part of their infection control programme to ensure all infections are documented, reported and data is included in quality reporting to staff, management and head office. The infection control programme is reviewed annually in January each year (documentation sighted).  Data is reviewed and analysed monthly to identify any significant trends or possible causative factors. Benchmarking occurs monthly at organisational level against 26 other facilities and three monthly against other like facilities by an offsite agency. This data confirms the service remains within acceptable infection numbers for the type and size of the service.  Management and staff reported during interview that any concerns or corrective actions taken are presented at staff meetings and the surveillance data findings are discussed. Hardcopy data results are posted on the staff notice board, as observed.  Staff report their awareness of the signs and symptoms of infections and stated they always report them to the registered nurse.  The infection control coordinator (RN) provided all required data to show how a Norovirus outbreak was managed in October 2016. All reporting occurred as required to meet legislative requirements. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service restraint minimisation and safe practice policy meets the requirements of the standard. Clear definitions of an enabler and a restraint are available to guide staff.  On the days of the audit the register reviewed listed eight residents using an enabler and 27 residents using a form of restraint. The resident records reviewed contained evidence that assessment for use has been conducted prior to use, alternatives had been tried, approval granted by the restraint committee and valid consent obtained by either the resident or their representative. There was evidence of ongoing monitoring and review of each restraint intervention. Enabler use was voluntary.  The clinical manager of the hospital is the restraint co-ordinator. The restraint coordinator maintains a list of all staff training and the relevant competency test completed annually by all staff. Feedback from staff was positive about training and knowledge on the service`s restraint philosophy and approach to restraint minimisation. All processes are clearly understood. |

# 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Resident file reviews show that assessment, planning, provision, evaluation and review of care is undertaken within required timeframes. The GP reviews residents within two working days of admission and undertakes regular reviews which includes a multidisciplinary review to include family/whanau at least six monthly. Whilst all resident care is reviewed six monthly, not all assessments are completed using interRAI. However, paper based assessments are maintained. The service has a documented process in place to get all assessments completed using interRAI. This includes employing two additional RNs on a part time basis to assist with interRAI assessment updates. Data identifies that in June 2016 there were 94 resident assessments not completed using interRAI and on the day of audit this number has been reduced to 40. | On the day of audit, the service has 40 residents who do not have up to date interRAI assessments. The service has a process in place to update all interRAI assessments. | Provide evidence that all resident assessments are being undertaken using interRAI.  180 days |

# 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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| No data to display |

End of the report.