

Heritage Lifecare Limited - Edith Cavell Home and Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited	
Premises audited:	Edith Cavell Lifecare	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 9 February 2017	End date: 10 February 2017
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:	55	

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

Edith Cavell Lifecare in Sumner Christchurch is certified to provide hospital and rest home level care for 63 residents. On the day of this certification audit there were 55 residents. There is a retirement village adjacent to the facility but this was not included in this audit.

This certification audit against the Health and Disability Services Standards and the provider's contract with the district health board (DHB), included observation of the environment, interviews with a senior manager, the management team and staff, review of documentation and interviews with residents and their families and a general practitioner.

There is one area that requires improvement relating to 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.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. A comprehensive Māori health plan and related policies guide care. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided are of an appropriate standard.

There is a complaints process that is understood by residents, family members and staff and meets the requirements of the Code. The manager maintains a current register.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation has a documented business and strategic plan in place which is reviewed regularly. The governing body is Heritage Lifecare Limited. The quality and compliance manager was onsite during the audit. A facility manager and clinical nurse manager oversee the day to day management of the facility. They both have position descriptions and the necessary skills,

knowledge and experience to perform their job. They are supported by the head office management team and regular reports flow between the two.

There is a quality and risk management system in place. This includes quality and clinical indicators, an internal audit programme and management of risks. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and corrective action planning links to the quality improvement system to manage any risks, and ensures quality improvement occurs. Quality improvement data collation is managed at the facility in an easy to read graph and text format. A written report is provided to head office weekly.

There are appropriate systems for the recruitment, appointment and management of all staff. Formal orientation and an ongoing education and training plan is provided/developed for all employees. Staff have a current performance appraisal and this process occurs annually.

The facility manager prepares the roster based on residents' needs, and safe staffing levels. The roster includes registered nurses, caregivers, laundry, cleaning, kitchen and activities staff. The current roster is adequate for the number of residents and their level of need.

A resident information management system is in place and information is entered in a timely and accurate manner. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The organisation works closely with the local Needs Assessment and Service Coordination Service (NASC), to ensure access to the facility is appropriate and well managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission, within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff and designated general practitioners. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a trained diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses only and care staff are second checkers, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has been purpose built with additional rooms added over the years. It is well maintained. Residents' rooms are kept clean, tidy, well ventilated and at a comfortable temperature. There are a number of communal areas which provide a variety of spaces for residents to use. There are enough toilets and bathrooms for the number of residents. The building has a current building warrant of fitness.

Easily accessed, safe and well maintained outside areas are provided for residents' use.

There are systems in place for the management of waste and hazardous substances by staff who have been trained in this area.

Emergency procedures are documented and available in several places around the facility. Regular fire drills occur and staff are well trained to respond in any emergency. There is a generator available and adequate supplies for civil defence and other emergencies. Appropriate security arrangements are in place.

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.
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The organisation has a commitment to restraint minimisation and safe practice. Safe policies and procedures are implemented. One restraint was in use and six enablers at the time of this audit. Enablers are used as a voluntary measure and aid independence. Written consents were on each resident's record reviewed. A comprehensive assessment, approval and monitoring

process was implemented. Regular reviews occur. Restraint is only used as a last resort when all other options have been explored. The restraint coordinator maintains the restraint register.

Staff interviewed are fully informed and are aware of the difference between restraint and enabler use. Staff have access to training on safe and effective alternatives to restraint at orientation and annually.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice is accessed from the district health board (DHB), microbiologist, infectious diseases physician, and group clinical advisory committee. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

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	49	0	1	0	0	0
Criteria	0	100	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Edith Cavell Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options to residents and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Registered nurses and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, and invasive procedures.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed at staff interviews.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports the philosophy of Quality of Life, caring, and living life to the highest level of independence.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family/whānau and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy which aligns with Right 10 of the Code. The facility manager and/or clinical nurse manager commences initial investigation of complaints with input as required from the organisation's quality and compliance manager. Complaints forms are visible and available at the front desk. A complaints procedure is provided to residents within the information pack on entry to the service. Ten complaints in 2016 and two in 2017 were included on the register. All have been resolved to the satisfaction of the complainant. The complaints register was up to date. Family and residents interviewed confirmed they knew the process for complaints, but none had reason to or made a complaint.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service) by the facility manager as part of admission process, from information provided, and from discussion with staff. The Code is displayed in the rest home and hospital entrance way (in English, Maori and sign language), at reception, in front of the office and nurses' stations, the dining rooms and lift. Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that</p>

		respects consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit while attending to personal cares, and by ensuring resident information was held securely and privately. Most residents have a private room and three rooms are shared by couples.</p> <p>Residents are encouraged to maintain their independence by staff ensuring individual care plans are followed, attending community activities, arranging their own visits to the doctor, and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Currently there are no Maori residents in the facility.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. Residents had dietary preferences and spiritual preferences documented. Interviews confirmed that staff ensure the residents' needs are met. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supports that individual needs are being met.</p>

values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner interviewed also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapists, occupational therapists, wound care specialist, mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for internal and external education through Careerforce training and there is evidence of a compulsory plan for all staff where staff are booked to attend education to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included extra fluid rounds, prompt answering of call bells, regular toileting rounds, and pressure injury prevention strategies.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the DHB or Older Persons Health when required. Staff knew how to do so, although reported this was rarely required due to all residents able to speak English. Staff able to provide interpretation as and when needed and the use of family members,</p>

		and communication cards are available for any potential residents for whom English is not their first language.
<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>Edith Cavell Lifecare is privately owned by a company. On the days of the audit there were 31 hospital and 24 rest home residents. The governing body is Heritage Lifecare Limited. The audit and compliance manager was on-site during the audit and verified the flow of information between the facility, head office and the board.</p> <p>The facility manager and clinical nurse manager oversee the day to day operation and both have been in their position for less than six months. The transition from the previous team to the new management has been guided effectively by head office. Residents, family and staff confirmed no disruption and were very happy with the new team and input from Heritage Lifecare Limited.</p> <p>The mission, vision and values of the organisation are documented in the strategic plan and quality plan. These are reviewed annually when progress against the objectives and goals in these documents are reviewed.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the facility manager (who is a RN), the clinical nurse manger assumes the role with assistance from the southern operations manager and the audit and compliance manager. Both have suitable experience for the roles. The facility manager will cover for the clinical nurse manager. At all times there is cover available from head office, should the need arise.</p> <p>Staff members interviewed reported that the facility manager, clinical nurse manager and registered nurses are providing stability as the management team of the facility and their respective areas of responsibility. Staff reported that they are approachable with an 'open-door' philosophy. This was observed during the audit. There is evidence of reporting to head office and the board at all meetings.</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</p>	FA	<p>There is a comprehensive quality and risk management plan specific for the facility, which is reviewed annually.</p> <p>The organisation's quality and compliance manager, in consultation with the organisation's facility managers, coordinates the development and review of all policies and procedures for the facility, and includes these changes as agenda items in all meetings. All documents reviewed during the audit were current, and some were in the process of review.</p>

<p>improvement principles.</p>		<p>The facility manager coordinates the quality and staff committee, which meets monthly through the year. A comprehensive agenda includes matter arising from last meeting, completed audits for the past month, adverse events, corrective actions, infection control and restraint minimisation, a report from health and safety committee, complaints and compliments, quality improvements, staff training, any ongoing developments, review of documents and staff issues. The separate health and safety committee meets every month. There is an organisation wide weekly operations report to head office that covers all aspects of service input and event reporting.</p> <p>The facility manager implements the internal audit calendar, or delegates audits to staff to complete. Those reviewed are detailed and complete with recommendations identified and implemented.</p> <p>Each month an analyses of quality data is collated by the clinical nurse manager and graphs of the adverse events are on display in the staff room. The report is also sent to head office who in turn report to the board. Staff members interviewed confirmed that they receive information about the events which occur in the facility and how these are managed. They also demonstrated an understanding of their responsibilities in the quality system appropriate to their role.</p> <p>There is a risk management plan, which identifies the risks to the business and includes strategies to mitigate these. The plan is very detailed and specifies the roles and responsibilities of all staff. This is reviewed regularly at the same time as the review of the quality plan and strategic plan.</p> <p>A corrective action plan is in place for any shortfalls. Those reviewed that have been completed were closed out. Three were still pending as these relate to January 2017.</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>FA</p>	<p>The incident and accident policy includes the essential notifications and statutory and regulatory reporting, including the requirement to report pressure injuries of category 3 under section 31 of the Health and Disability Services (Safety) Act. At interview, the facility manager demonstrated clearly her responsibility in this area and explained the process, for example, for pressure injury reporting.</p> <p>Adverse events are reported and recorded on appropriate event reporting forms. The data from collated adverse events is summarised by the facility monthly and reported at meetings, to head office and in graph form on the staff room notice board. Staff confirmed that they report events using the reporting forms, or verbally to the facility manager. They understand the importance of reporting and recording events.</p> <p>General practitioners (GPs) are notified of adverse events when they occur and this was confirmed during interview with one GP who visits the service and when reviewing event forms. Residents and family members reported that they are also notified of events and appreciate receiving this information.</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>FA</p>	<p>Policies and procedures for recruitment, appointment and management of staff reflect current legislation and good employment practice. All recruitment is managed by the facility manager with the assistance of the organisation's southern operations manager if required. Both were interviewed during the audit. All appropriate checks are undertaken during the appointment process and this was confirmed during a review of personnel files. Professional qualifications are verified and monitored annually. Records reviewed verify current practising certificates / professional registrations for registered nurses, medical practitioners and allied health professionals. Personnel files reviewed confirmed that performance appraisals are also current.</p> <p>A comprehensive training and education programme is available for all staff. This includes an orientation and induction programme and ongoing annual training. The facility and clinical nurse managers maintain a training register, which includes essential training, competencies, and other in-service and external training attended by staff. The programme includes wound and pressure injury management.</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>An organisation wide staffing policy is in place to alter staffing according to the skill mix and residents' needs. Rosters are the responsibility of the facility manager with input from the clinical nurse manager. Three weeks of non-consecutive rosters reviewed verified adequate care staff on every shift throughout the facility and across all shifts over 24 hours and seven days a week.</p> <p>There are two cooks, eight kitchen hands, three cleaners, two laundry staff, a maintenance person, and a contracted gardener. Two diversional therapists five days a week provide oversight of activity plans and programmes. Both managers are RN's and share on call. The current staffing levels meet the requirements of residents.</p> <p>Residents, family, staff and the GP interviewed reported that there are sufficient numbers of suitably skilled staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review.</p> <p>Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p>

		<p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families/whanau are encouraged to visit the facility prior to admission and meet with facility manager (FM) and clinical nurse manager (CNM). They are also provided with written information about the service and the admission process. The service operates a waiting list for entry. The organisation seeks updates information from NASC and the GPs for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, 24 hours of medication, 24 hours of progress notes, wound charts (where applicable), and advance directives are provided for the ongoing management of the resident. A checklist ensures this occurs. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility, showed a planned, co-ordinated transfer to the acute care service and transition back again. Family members of the resident reported being kept well informed during the transfers of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using 'Medimap' and a blister pack system was observed on the days of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All</p>

<p>and safe practice guidelines.</p>		<p>staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. Standing orders are rarely used but processes are in place to enable safe administration and appropriate documentation.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the clinical nurse manager and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</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>The food service is provided on site by the kitchen manager and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to</p>

		<p>meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were observed to be given sufficient time to eat their meal and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC service is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC service is made and a new placement found, in consultation with the resident and family/whānau. Examples of this occurring were discussed with the Facility Manager. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>Information is documented using validated nursing assessment tools, such as a pain scale, skin integrity, nutritional screening, falls risk, continence assessment, activity assessment and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents' files reviewed during the audit had a current interRAI assessment.</p> <p>Residents' six monthly interRAI assessments were being completed after the six month care plan review in the lifestyle care plans reviewed, rather than the interRAI assessment occurring before and therefore informing the care plan review, as required D16.3d.</p> <p>It is noted that the interventions triggered in the interRAI assessment were included in all the care plans reviewed therefore mitigating the risk.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as a pain scale, skin integrity, nutritional screening, falls risk, continence assessment, activity assessment and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents' files reviewed during the audit had a current interRAI assessment.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP and physiotherapist interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard at Edith Cavell Lifecare. RNs and care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by one trained diversional therapist (DT), and one diversional therapy assistant who has nearly completed the diversional therapy training through Careerforce.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as their needs change, monthly, and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included musicians playing music and singing, planned outings, individual outings, volunteers coming to read to residents, and children's groups coming to visit.</p> <p>The activities programme is discussed at the minuted residents' meeting and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme encourages them to reach their highest level of independence within the limitations they have.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months or as residents needs change. Six-monthly interRAI reassessments are occurring, or more frequently as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for urinary tracts infections (UTIs), falls, infections, any changes in the resident's normal status and</p>

		progress evaluated as clinically indicated at least weekly and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Residents are supported to access or seek referral to other health and/or disability service providers. All residents have the choice of their own GP. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the physiotherapist, needs assessor, gerontology clinical nurse specialist, diabetes nurse specialist, wound care specialist, geriatrician, and older persons' mental health services. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	There are policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes policy around safe storage and handling of chemicals. Waste is appropriately managed. All chemicals sighted were stored securely. Staff interviewed demonstrated knowledge of handling chemicals and were observed using personal protective equipment.
<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 current building warrant of fitness expires 1 January 2018. There have been no changes to the building since the previous audit.</p> <p>Residents and family members interviewed during this audit reported that they find the environment is maintained to a high standard at all times and it is well presented. There is a regular system for preventative maintenance, relevant electrical safety testing, and calibration of equipment. This was maintained and current. All hazards have been identified in the hazard register.</p> <p>Outside areas were easily accessed from the facility and were well maintained.</p>
Standard 1.4.3: Toilet, Shower, And	FA	There is a mix of residents' rooms with full or toilet only ensuites, and other rooms with hand-

<p>Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>washing, soap dispensers and paper towels only. There are sufficient showers and toilets for residents. Separate visitor and staff toilets are available.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Residents' rooms are spacious enough to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents can occur and equipment can be transferred between rooms. Mobility aids can be managed in communal rooms.</p> <p>Rooms were observed to be personalised with furnishings, photos and other items and the service encourages residents to bring in personal items.</p> <p>There was room to store mobility aids such as walking frames safely.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The facility has several communal lounge/dining areas. There are smaller seating areas for residents and families within the facility. Furniture in all areas is arranged to allow residents to freely mobilise. Residents and families interviewed verified that the facility has sufficient space and residents may stay in their own areas or use any of the communal lounges.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is completed on site in a spacious laundry. A survey of residents and family confirmed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. All chemicals sighted were labelled. Material safety datasheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate</p>	<p>FA</p>	<p>There is at least one staff member on duty at all times with a first aid certificate. Emergency plans are accessible to staff and includes management of all potential emergency situations. The organisation has policies and procedures for civil defence and other emergencies. There are enough</p>

<p>and timely response during emergency and security situations.</p>		<p>supplies available, such as dressing and first aid equipment. There is an approved evacuation plan for the facility. Fire evacuation training and drills are conducted six monthly.</p> <p>Emergency equipment, water and food are available in a separate area and routinely checked.</p> <p>Appropriate security systems are in place. The call system functions throughout and when activated is responded to promptly. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Residents' rooms are provided with adequate natural light, ventilation, and an environment that is maintained at a safe and comfortable temperature. Temperatures are routinely monitored.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the clinical co-ordinator/infection prevention and control officer (IPC). The infection control programme and manual are reviewed annually.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical nurse manager, facility manager, and tabled at the quality/risk committee meeting. This committee includes the facility manager, clinical nurse manager, IPC coordinator, and the health and safety officer.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the</p>	<p>FA</p>	<p>The infection prevention and control (IPC) coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role at Edith Lifecare since November 2016 and in a</p>

<p>infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>previous facility as an IPC co-ordinator for a number of years. She has undertaken IPC training and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control nurse specialist, Older Persons' Health are available and expert advice from the laboratory is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There has not been an outbreak since the last audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are reviewed yearly and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>When an increase in infection incidence has occurred, there is evidence that additional staff education has been given.</p> <p>Education with residents is generally on a one-to-one basis and has included, reminders about handwashing, and advice about remaining in their room if they are unwell. Families confirmed they are given education if their family/whanau member is unwell.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the individual infection register in the resident's clinical record, infection reporting form, and resident management system. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical nurse manager, facility manager and head office.</p> <p>New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies and procedures for the use of restraints and enablers which comply with the standard. All alternatives to restraints are considered and used before any restraint is used.</p> <p>On the days of audit there was one restraint in use and six residents with an enabler. The restraint used was a convex mattress sleeve and the enablers bed loops. The restraint coordinator is the clinical nurse manager and was interviewed in relation to this standard. She has attended all training provided at the facility. She demonstrated her understanding of restraint and enabler procedures.</p> <p>Restraints and enablers are approved, monitored and reviewed. Two residents' files (of a person using an enabler and a person using a restraint), were reviewed and all documentation was current and as described in the organisation's policies and procedures.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service</p>	<p>FA</p>	<p>The clinical nurse manager is the restraint co-ordinator and heads the restraint committee. The restraint committee is made up of the facility manager, clinical nurse manager, a registered nurse, and one care staff member. The committee is responsible for the approval of the use of all restraint processes, as defined in the restraint minimisation and safe practice policies and procedures. This was evidenced in the minutes of the restraint meetings, review of residents' records and interview with the restraint coordinator, and the clinical manager. There are clear lines of accountability for the approval group to follow. All restraints have to be approved, and the overall use of restraints is being monitored and analysed.</p> <p>Restraint training is provided at least annually. Any staff that were unable to attend completed a</p>

<p>providers and others.</p>		<p>questionnaire and this was recorded. Staff during interview demonstrated knowledge in restraint minimisation and the processes for monitoring restraints and enablers.</p> <p>The convex mattress sleeve on the resident's bed is working effectively. The facility manager sends all details to head office relating to restraint and enabler use in the weekly report.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint is documented on an assessment form that includes all requirements of the standard. One record of the person using a restraint was reviewed. A convex sleeve mattress is in use for this resident. Restraint minimisation and safe practice consent approval form was sighted and had been signed by the family member with enduring power of attorney (EPOA) and by the general practitioner. A plan was developed and implemented for the individual resident. Monitoring frequency was documented and completed as requested on the plan. Six monthly review with outcomes documented were reviewed and this was signed off by the restraint co-ordinator after discussion at the restraint committee.</p> <p>Cultural considerations, alternatives and desired outcomes to ensure the resident's safety and security was documented. Independence was encouraged for all residents using a restraint and/or enabler.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>Restraint monitoring forms are used to record each episode of restraint use. When restraints are in use, two hourly monitoring occurs to ensure the resident's cares are being effectively met with recording of all cares, nutritional input and safety considerations required. The monitoring form is kept in the resident's record and used by the restraint coordinator for monitoring of the restraint use and to ensure the requirements of the policy are met. This was completed in the resident's record reviewed where restraint was in use. The mattress is only in use during times when the resident is in bed.</p> <p>A restraint register is maintained by the restraint coordinator, updated monthly and reviewed at each quality and all staff meeting and restraint committee meeting when each resident using a restraint is discussed. Minutes of the meetings were available.</p> <p>Staff have received training on restraint minimisation and safe practice. Policies and procedures are understood by staff and the safe use of restraint is considered at all times. Minimisation was encouraged and safe use was confirmed during staff interviews.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The review of a resident's record evidenced the individual use of restraints is reviewed and evaluated monthly by the restraint co-ordinator, and six monthly as part of the lifestyle care plan and interRAI reviews, with input from family/EPOA, wherever possible and documented by the general practitioner concerned.</p> <p>The evaluation includes all requirements of the restraint minimisation and safe practice standard, and in some cases, future options are developed to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation was completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint co-ordinator reviews all restraint use on a monthly basis, which includes all the requirements of the standard. Minutes of the restraint committee and quality and all staff meetings confirmed analysis and evaluation of the types of restraint used in the facility, whether alternatives to restraint have been addressed and the effectiveness of the restraint in use. The restraint coordinator reports to head office if any trends are identified.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	<p>There is planned InterRAI assessments and six-month care plan reviews consistently occurring, however residents six monthly interRAI assessments were completed after the six month care plan review in eight of eight lifestyle care plans reviewed, rather than the interRAI assessment occurring before and therefore informing the care plan review.</p>	<p>The clinical nurse manager provides input and oversight for interRAI assessments and lifestyle care plans and reviews are occurring six monthly; however, the interRAI assessments are occurring after the six month lifestyle care plans are completed.</p>	<p>Ensure all residents' six monthly care plans are reviewed and updated, as needed, following the interRAI six monthly assessments are completed.</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.