# Taumarunui Community Kokiri Enterprises Limited - Te Arahina O Arihia Rest Home

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Taumarunui Community Kokiri Enterprises Limited

**Premises audited:** Te Arahina O Arihia Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 10 April 2017 End date: 11 April 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:** 13

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Te Arahina O Arihia Rest Home provides rest home level care to a maximum of 15 residents.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family, management, staff, and a general practitioner. All interviewees spoke positively about the care provided.

The service is owned and operated by the Taumarunui Community Kokiri Trust with day to day oversight from a full-time manager. This person was not on site for the audit but was interviewed by telephone. The chief executive officer (CEO) and operations manager were interviewed and members of the board were on site for parts of this audit. The service discontinued providing dementia care in September 2016 and has had a significant change in staff since the previous audit.

This audit resulted in eight identified areas requiring improvement. Three of these relate to the quality system, where there needs to be more effective review of policies and procedures, formal analysis of quality data and evidence that corrective actions are resolved. An improvement about the frequency of staff appraisals and care planning is required, and there are three areas of non-compliances in the restraint minimisation standard.

## 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 their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and these rights are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident’s needs.

The complaints policy and procedures comply with right 10 of the Code. A complaints register is maintained. This contains information about the nature of the complaint, and details about investigations and outcomes. There has been one external complaint received by the Ministry of Health (MoH) and the DHB. Investigations have occurred and any matters requiring improvement had been agreed between the provider, the DHB and MoH prior to this certification audit.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring reports about service delivery are provided to the governing body regularly. An experienced and suitably qualified person manages the facility with support from registered nurses.

The quality and risk management system is documented. Quality activities are reported against. Adverse events are documented with corrective actions identified. Actual and potential risks, including health and safety risks, are identified and mitigated. The policy and procedure set is designed to support service delivery.

The appointment, orientation and management of staff is based on current good practice. A new approach to delivering ongoing training to staff has been implemented this year. Staffing levels and skill mix meet the changing needs of residents.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people.

## 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. |

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident and family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. 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. |

The facility is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested annually. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The restraint policy meets the requirements. Some procedures had been followed for a resident who was recently identified as requiring bedrails as a safety measure when in bed. There were three residents who had requested and were voluntarily using enablers to prevent harm and to assist their mobilisation. Staff training in the safe and appropriate use of restraint and enablers has been occurring.

## 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 programme, led by a trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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 | 44 | 0 | 3 | 3 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 5 | 3 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The facility 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, 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. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent had been gained appropriately using the organisation’s standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and was documented, as relevant, in the residents’ records. Staff were observed to gain consent for day to day care. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The registered nurse provided a contact list of advocates in the community. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | 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 has unrestricted visiting hours and encourages visits from residents’ family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. The residents and families interviewed said they has been provided information about the complaint process on admission and would have no hesitation raising concerns with staff or management.  The complaints register reviewed contained four complaints that had been received since 2016. An anonymous complaint about resident care, incidents, staffing and medicines was investigated by the DHB and Ministry of Health in March 2017. The investigation did not substantiate all the matters raised in the complaint but recommendations were made and improvements have been actioned. The facility manager interviewed by telephone stated that scanned paper copies of concerns received from staff about other staff and from residents about other residents, received in 2016 had been deliberately deleted from the electronic database along with the complaints register. These have subsequently been retrieved. The organisation has reviewed its systems for securing data and has implemented steps to prevent recurrence.  The complaints register and individual complaint forms records the date and nature of the complaint, how it was acknowledged, results of investigation and when and how the complaint was resolved. The operations manager is currently responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service). Information is provided in the information pack and admissions agreement. The Code is displayed in the main areas of the facility together with information on advocacy services, how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by partaking in community activities, arranging their own visits to the doctor and participation in clubs of their choosing. Care plans included documentation related to the resident’s abilities, and strategies to maximise independence.  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.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | 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 whānau. All four residents who affiliate with their Maori culture are supported with a current Māori health plan developed with input from cultural advisers which was specific and individualised to meet their needs. Guidance on tikanga best practice is available and is supported by staff who identify as Māori and Maori language signage was evident throughout the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident’s personal preferences, required interventions and special needs were included in care plans reviewed, for example food, spiritual beliefs. The resident satisfaction survey confirmed that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice however not all policies reviewed have update supporting evidence (refer to criterion 1.2.3.3). Input from external specialist services and allied health professionals (eg, hospice/palliative care team, diabetes nurse specialist and 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.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Families and residents interviewed were happy with the external support services provided. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/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. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code.  Staff know how to access interpreter services, although reported this was rarely required due to whanau support. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | On the days of audit there were 13 residents including two people on short stay respite. Three long term residents are under the age of 65 years and funded by the Ministry of Health DSS contract for young people with disabilities. The needs of these younger residents are provided for in the form of different activities and support to access to community resources of their choice. All other residents’ cares are sufficiently provided for under the aged residential care agreement.  The Taumarunui Community Kokiri Trust has owned and operated the aged care facility since 2003. The sighted five year strategic plan for the organisation and annual plan for the lifestyle/rest home, contain a philosophy, values, mission and goals. Interview with the CEO and operations manager and review of board meeting minutes showed these plans are regularly monitored for progress via the monthly CEO reports to the Board. The facility manager also provides written reports to the board which detail occupancy, and other operational matters. The facility manager has been employed by the Trust for a number of years as the human resource (HR) manager and assumed the role of facility manager in 2015. This person is suitably qualified as a manager with input and support with clinical matters from the registered nurses. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The facility manager is on leave and the operations manager and a designated and additional registered nurse (RN) are currently carrying out all the required duties. The operations manager has the delegated authority for the facility management. During absences of key clinical staff, the clinical management has been overseen by another part time RN who is experienced in the sector and able to take responsibility for any clinical issues that may arise. This person is booked to undertake interRAI training. Staff reported the current arrangements are working well. |
| 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. | PA Moderate | The organisation has established quality and risk systems which includes the reporting and management of incidents and complaints, internal audit activities, regular resident and whanau satisfaction surveys, contract reporting, and reporting of infection events. The pre-audit document review identified there was a need to review clinical policies and procedures to ensure they meet current legislation and known best practice.  Interview with staff and management and review of documents show that the number of incidents, complaints, infections and results of internal audits is submitted electronically to the organisation’s quality assurance committee each month and some aspects of this are discussed at team meetings. There is no evidence that this information is being compared or analysed for trends. Furthermore, there is scant evidence that the recommendations and corrective actions identified to address any shortfalls have been implemented and monitored.  Resident and family satisfaction surveys are being completed annually. The most recent survey in November 2016 showed medium to high satisfaction. Where the surveys indicated follow up was required, this had been undertaken by the operations manager and facility manager.  The operations manager and the CEO described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Although these people are familiar with the requirements of the Health and Safety at Work Act (2015) and regular health and safety checks are carried out, the current policies do not reflect the new legislation. |
| 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 | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed and that the incidents were investigated in a timely manner, usually the same or next day, by either the facility manager or the registered nurse. Although the total number of events is collated and reported monthly, this is not being sufficiently analysed and there is no evidence that recommendations are being tracked and monitored for implementation and effectiveness. There are corrective actions required in standard 1.2.3 related to this.  Management staff interviewed clearly understood the requirements around essential notification reporting, including for pressure injuries. Notifications about changes in management and service scope have been made to the Ministry of Health and DHB since the previous audit. An issues based audit into clinical practices following an anonymous complaint in early 2017 has occurred and the findings are being openly addressed. |
| 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. | PA Low | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation. There is a need to formalise and document a review of new staff competence and suitability for the role after their three-month probation period.  There has been a recent review and changes to the way staff training is occurring. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. The registered nurse is sufficiently trained and competent to undertake interRAI assessments. There is evidence this person is also maintaining their annual competency requirements.  Review of a sample of staff files, staff and management interviews, reveal that 70% of staff have not had an annual performance appraisal. |
| 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 and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Interviews with staff and residents confirmed that staff levels are adjusted to meet the changing needs of residents. Night staff confirmed that ready access to advice or physical support is available when needed from the on call registered nurses. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. The records of staff training confirmed that all but three staff (who are not care staff) have current first aid certificates .There is always a staff member on duty with a current first aid certificate and a RN on call 24/7. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Disability Services Limited (DSL) Service. Eleven of eleven residents have been assessed and confirmed by the local Needs Assessment and Service Coordination (DSL) Service as requiring rest home level care. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from DSL and the GP for residents accessing respite care.  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. Service charges comply with contractual requirements.  The facility has contracts to provide rest home, and respite care and care for people with disabilities under the age of 65. On the day of audit there were three residents under the age of 65 and 11 residents receiving rest home level care. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and coordinated 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/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed the implementation of the ‘yellow envelope’ and associated paperwork. Family of the resident reported being kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy and identifies all aspects of medicine management and includes scanned pages from the Medicines Care Guide for Residential Aged Care. The policy also cites the five rights when administering medication not seven (refer to criterion 1.2.3.3).  A safe system for medicine management (using an electronic system) was observed on the day 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. Each shift is supported by staff who administer medicines and are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries. At the time of audit the pharmacist completed an audit of the controlled drugs book.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  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 electronic medicine chart. Standing orders are used, however the review date at time of audit had expired on the 4 April 2017, and the RN stated that standing orders had not been implemented since this day and by day two of audit all standing orders had been reviewed, updated and resigned by the GP and comply with guidelines.  There is one resident who self-administered medications (insulin) at the time of audit. Three monthly reviews were evidenced. The insulin is stored in the treatment room and when required the medication competent staff member dials up the prescribed amount. The resident then self-administers the insulin under supervision. Processes are in place to ensure this is managed in a safe manner which includes a care plan in the event of a hypoglycaemic event.  There is an implemented process for comprehensive analysis of any medication errors. |
| 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 | The food service is provided on site by a cook 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.  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. The cook has undertaken an updated safe food handling qualification in March 2017.  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 the cook 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 meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local DSL 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 DSL is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools such as (pain scale, falls risk, skin integrity, nutritional screening, as a means to identify any deficits at time of admission. Risks/triggers are also identified thru the use of interRAI assessments to support and inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by a trained interRAI assessors on site. A second RN is booked to commence training. Residents and families confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed however not all long plans identified residents requiring frequent use of antibiotics term care.  Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | 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. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is provided at a high level. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs which included incontinence and dressing supplies. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by an activities co-ordinator who has recently completed the national Certificate in Diversional Therapy. 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 three monthly and as part of the formal six monthly care plan review.  Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered to meet the needs of residents over and under the age of 65. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings and satisfaction surveys. Residents interviewed confirmed they find the programme meets their needs.  The role of the activities co-ordinator includes the escorting and transport of residents to GP/hospital appointments when family are unavailable. Due to an increase recently in family being unavailable, the activities co-ordinator has been required to be off site frequently. A discussion was had with the management team who have stated that they will review this practice to ensure that all residents within the facility have equal time with the activities co-ordinator and the residents can look forward to and enjoy planned calendar events. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care however not all interventions had care plans (refer to criterion 1.3.5.2). Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a ‘house doctor’, residents may choose to use another medical practitioner. 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 radiology and physiotherapy. The resident and the family/whānau 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. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry 20 May 2017) was publicly displayed. There have been no structural changes to the building with the change in service scope. Keypad door locks have been removed and all bedrooms are now for single occupancy. Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio-medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment.  Staff ensure the environment is hazard free, that residents are safe and independence is promoted.  External areas are safely maintained and are appropriate to the resident group and setting. Water blasting of external walking paths is scheduled to occur. Residents and family members said that they were happy with the environment. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes two toilets and a separate shower room in each wing (for a maximum seven residents) plus an extra toilet next to the large lounge. There is a separate toilet designated for staff/visitors. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms are now for a sole occupant. The larger previously shared bedrooms are allocated to residents with mobility equipment. Currently, one of the 15 bedrooms is being used to store equipment, surplus mobility aids and wheel chairs. Rooms are personalised with furnishings, photos and other personal items displayed. Staff and residents reported the adequacy of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. The large dining and two lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is undertaken on site by care staff. The staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents and family interviewed reported the laundry is managed well and that residents’ clothes are returned in a timely manner.  There is one designated cleaner who has been in the role for many years and attends appropriate training. Basic cleaning is also undertaken by care staff on different shifts and at the weekends. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.  Cleaning and laundry processes are monitored through the internal audit programme and resident and family feedback. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in June 2000. The deconstruction of the secure unit did not require this to be reviewed or updated. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 06 April 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ’s were sighted and meet the requirements for a maximum of 15 residents. Taumarunui civil defence provides water storage tanks close to the facility and generators are available. Emergency lighting is regularly tested.  Call bells alert staff to residents requiring assistance and staff were observed responding promptly to these. Residents who are at risk of falls or wandering at night have sensor mats in place. Night staff interviewed confirmed they regularly check these are working and plugged in and that the floor mats being used to disguise these have reduced the issue they had about residents avoiding standing on them.  Appropriate security arrangements are in place. Doors and windows are locked at a pre-determined time each night and entry or exit through doors other than the main door, triggers an alarm. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, and large opening external windows. Heating is provided by electrical panel heaters in residents’ rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive infection control manual, however this was last reviewed in 2014 (refer to criterion 1.2.3.3).  The 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 at staff meetings, monthly to the facility manager and tabled at the board meetings.  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 responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for six months. She has undertaken online training in infection prevention and control, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention programme, however policies were last reviewed in 2014 (refer to criterion 1.2.3.3)  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 were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | 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 RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. There has been no recent history of infection outbreaks or an increase in infection incidence.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | All staff are required to take responsibility for surveillance activities. Monitoring is discussed in handover and staff meetings to reduce and minimise risk and ensure residents’ safety. The service monitors skin and soft tissue wounds, pressure injuries, urinary tract infections, oral, eyes, ear, and gastroenteritis infections. Antibiotic use is also monitored. The infection control coordinator collates monthly and annual activity of individual results, however does not identify and/or analyse possible causative factors, trends (refer to criterion 1.2.3.6). Information is fed back and discussed in management, staff and where appropriate, family and resident meetings.  Data collected identifies two residents who are chronically unwell and frequently require antibiotics. Evidence of interventions were included in GP and progress notes, fluid balance charts and written handover information, however long term care plans did not include interventions in place to reduce and minimise the risk of infection. (Refer to criterion 1.3.5.2) |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint minimisation and safe practice policy contains clear descriptions and guidelines on restraint/enabler procedures. There is a documented definition of restraint and enablers which is congruent with the definition in the Standard. On the day of audit one resident has bedrails in place as a restraint and three residents were using enablers (bed rails, laps belts), which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. There was a restraint register. Staff training on restraint and managing challenging behaviour is provided regularly. The full time registered nurse is the designated restraint coordinator.  Restraint is used as a last resort when all alternatives have been explored. This was evident in team meeting minutes, files reviewed, and from interview with staff. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The service has an appropriate and clearly defined approval process which is implemented. The type of restraints approved for use are documented in the policy. These include lap belts, harness, 'fall out' chairs and bed rails. The policy and restraint folder is available to all staff and restraint is discussed at monthly staff meetings. Evidence of family/whānau and GP involvement in the decision making was on the file of the one resident who has bed rails in place. Use of a restraint or an enabler was part of the plan of care. Alternatives to restraint were trialled as part of the assessment process. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Moderate | Although the policy describes assessment processes, there was insufficient evidence that full assessment had been completed prior to initiating bedrails for a resident recently. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Low | The use of restraints is actively minimised as demonstrated by the low rate of restraints in place and alternatives in use, such as the use of sensor mats.  When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.  There was no restraint register or recent history about restraint use on site. This was amended on the day of the audit.  Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraint is to be minimised and how to maintain safety when in use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Review of electronic files for 2016 showed that the individual use of restraints was being reviewed three monthly and evaluated during care plan and interRAI reviews. The evaluation considered safe continuation of restraint, changes in the resident’s status and care plans and if monitoring was completed as required. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | PA Moderate | Restraint activity was being discussed at team meetings and being reported to the organisation’s quality committee each month, but there has not been a quality review of restraint practices in the past 12 months. The requirement for regular monitoring and quality review of restraint is described in policy and has not been adhered to. |

# 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 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | The pre-audit document review identified deficiencies in the content and extent of the policies and procedures. Guidelines for new processes such as interRAI had not been developed, and the policy reviews were not taking into account changes in practice or new legislation. | Although the system indicated that policy reviews had been occurring annually, these reviews had not identified required changes or additions (for example, an interRAI policy had not been developed). A number of policies require updating to meet current best practice and new legislation, for example, wound/skin/care pressure injury, infection control, consumer records, health and safety. | Ensure that the policy and procedure set is thoroughly reviewed and changes are made where required.  180 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Review of the monthly quality summary reports which are submitted to the organisation’s quality assurance committee, and corresponding data for 2016-2017, for example, incident and accident reports, complaint and infection event reports, plus management reports to the Board and the results of internal audits do not include narrative or discussion about the quality statistics or results. Interviews with management and other staff confirm the process has not included studying the data for any positive or negative trends or patterns that highlight the impact of practice on outcomes. | There is insufficient evidence that the quality data being collected is analysed or compared. A number of the quality tools in use, for example, the records audit tool and the incident summary sheet, are difficult to interpret and do not produce easy to understand data. | Review the tools that are being used for internal auditing, and the systems for collecting and reporting quality data. Ensure that quality data is analysed and evaluated in ways that identify positive or negative trends.  180 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Review of the 2016-2017 incident reports, results of internal audits, and reports to the Board and the quality committee do not discuss what has been done to remedy shortfalls or prevent recurrence. The staff interviewed described the actions that had taken place but were not able to evidence that the actions were effective or that they had tested/evaluated or checked that the actions or remedies had solved the problem. In the case of a serial faller, the ongoing action required was for staff to check the resident had not disconnected their sensor mat and for staff to assist with standing and sitting. Subsequent reports about this resident’s falls did not consider the presence of staff or the status of the sensor mat or suggest other strategies to mitigate falls. | Where incident reports and internal audit tools identified areas that needed improvement, remedial actions are recorded but there was no evidence that these actions were implemented or followed up on. | Provide evidence that corrective actions have been implemented and then reviewed for effectiveness.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | The sample of staff records reviewed (four of five) did not contain evidence of performance appraisal. Five staff said they had either not had a 90-day review or had not engaged in a performance appraisal since 2015. The manager interviewed by phone confirmed that 70% of staff were overdue for performance appraisals. This was due to the manager being on long term sick leave. | The system for evaluating new staff and monitoring staff performance is not being adhered to. Although the manager stated that she engages in frequent 1:1 discussions with individual staff about their work, these discussions are not documented. The majority of staff are overdue a formal performance appraisals, and new staff have not been signed off as meeting requirements after their 90-day probation period. | Ensure all new staff engage in a 90-day post-employment appraisal, and that all other staff performance is formally reviewed at least annually.  180 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Evidence of required support and/or intervention of identified ongoing assessment documentation was identified in verbal and written handovers, resident’s progress notes, GP discussions. Five of five residents’ files evidenced long term care plans; however, two of five residents did not have specific care plans to identify frequency of infections and evidence related interventions to reduce and minimise the risk of infection. It was evident from staff interviewed that they knew the residents well. Family and residents interviewed stated they were happy with the care provided. The GP interviewed stated that he was happy with the care provided. | Not all residents have identified interventions related to infections documented in long term care planning. | Ensure that residents have long term care plans to meet the needs of the residents and contractual requirements.  180 days |
| Criterion 2.2.2.1  In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies. | PA Moderate | The restraint file did not contain a longitudinal log of past and present restraints. Interviews with the RNs revealed that they knew who had been using enablers or restraints and the only way to gather proof of this was to conduct an electronic search of the database. | There was insufficient evidence that assessment for the safe use of restraint had occurred prior to initiating the restraint, for example, no risks related to the use of restraint were identified. The new RNs require education and support to better understand all the requirements of this standard. | Ensure that the RNs understand these requirements and that the process for assessing the need for restraint is documented. The assessment needs to take into account all the factors identified in this criterion.  90 days |
| Criterion 2.2.3.5  A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use. | PA Low | The restraint file did not contain a longitudinal log of past and present restraints. Interviews with the RNs revealed that they knew who had been using enablers or restraints and the only way to gather proof of this was to conduct an electronic search of the database. | Staff knew who was using bedrails or other equipment for safety and to assist mobilisation, but records for what restraints had been in place for 2016 and up to 2017 were not readily accessible. There is no simple process for determining the extent of restraint or enabler use in the facility. | Maintain an up to date restraint register or other similar process to provide an easy to access and accurate account of past and present restraint use.  90 days |
| Criterion 2.2.5.1  Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education. | PA Moderate | Interview with clinical staff and management revealed they were not aware of the need to conduct a comprehensive quality review of restraint practice. This is described in the organisations policy and procedures and has not been completed. Had this been completed it may have identified areas for improvement and strengthened staff knowledge about restraint. | There is no evidence of a formal and comprehensive review of restraint activity having been conducted since 2015. | Conduct a comprehensive review of all restraint activity within the facility over a period of time as determined by policy. This review needs to consider and report on all the aspects required in this criterion.  90 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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End of the report.