# Sunrise Healthcare Limited - Lynton Lodge 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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Sunrise Healthcare Limited

**Premises audited:** Lynton Lodge Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Residential disability services - Physical

**Dates of audit:** Start date: 15 May 2017 End date: 16 May 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:** 35

# 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

Lynton Lodge Hospital can provide care for up to 40 residents. Occupancy on the day was at 35.

The audit process for certification was conducted against the Health and Disability Standards and the service contract with the district health board. The audit process included the review of policies, procedures and resident and staff files, and observations and interviews with residents, family, management, staff and a medical officer. The nurse manager is responsible for the overall management of the facility, including clinical care, and is supported by the two managing directors. Service delivery is monitored.

Improvements at certification is required to the following: privacy, informed consent, assessments, medication, restraint and maintenance.

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

Resident’s information packs regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are provided to all new residents, and displayed within the service. Residents and family members interviewed by the consumer auditor confirmed their rights and cultural needs are met, staff are respectful of their needs and communication is appropriate.

Residents, families and enduring power of attorney are provided with information required prior to giving informed consent. Time is provided if any discussions and explanation are required relating to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).

The nurse manager is responsible for management of complaints. A complaints register is maintained. Complaints are managed as per timeframes in the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights.

## 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. |

Lynton Lodge Hospital is a privately owned facility. The two directors form the governing body and are responsible for the services for the facility. The service has a documented quality and risk management system. Risks are identified and the hazard register is up to date. Adverse events are documented on incident and accident forms. Quality improvement data is collected, collated, analysed and reported through the use of their national quality system.

There are human resource policies implemented around recruitment, selection and orientation. Staffing rosters are adjusted to meet numbers of residents in the facility and acuity levels. Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

Staff education records confirmed in-service education is provided. The nurse manager validates annual practising certificates for health professionals who require registration with their professional bodies. The nurse manager is available after hours if required for clinical support.

## 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 medium or high risk and/or unattained and of low risk. |

The service works with the Needs Assessment Coordination Service to ensure safe and appropriate entry into the service.

All residents' needs are assessed on admission by a registered nurse. Nurses use initial nursing risk assessments for data collection to create initial care plans. Residents and their families contribute to care planning and evaluation of care.

Planned activities are managed by a diversional therapist and appropriate to the group setting. Resident and family interviews confirmed satisfaction with the activities programme. Residents under the age of 65 have additional activities recorded. Activities are provided either within group settings or on a one-on-one basis.

There is a medicine management system in place. Review of resident files confirmed administration records are accurate and there is timely review of medicines by the general practitioner. There were no residents self-administering medicines.

The menus are meeting national nutritional guidelines for older people, and have been reviewed by a registered dietitian. Residents’ special dietary requirements and needs for assistance are met. 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Building and plant comply with legislation, with a current building warrant of fitness in place. The environment is appropriate to the needs of the residents. A maintenance programme is in place.

Residents are provided with accessible and safe external areas. Residents’ rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Essential emergency and security systems are in place, including processes for the management of environmental restraint in emergencies and fire drills are completed every six months. Call bells are available to all residents and are monitored monthly.

## 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. |

Policies and procedures for restraint minimisation and safe practice are aligned with the requirements of the standard. Staff complete annual education and training on restraint and enabler management processes.

At the time of the on-site visit, there were two enablers in use and six restraints being used.

## 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. |

The infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection according to the requirements of the standard. Infection prevention and control is included in induction and orientation of new staff. The service has ongoing infection control education and training available for all staff.

The surveillance programme is appropriate for the size and complexity of the services provided. Surveillance of infections is occurring according to the descriptions of the processes in the infection control programme. Data is collected, collated, analysed and reported through all levels of the organisation, including governance. The infection control surveillance data is benchmarked externally.

## 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 | 2 | 4 | 0 | 0 |
| **Criteria** | 0 | 95 | 0 | 2 | 4 | 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 | Lynton Lodge Hospital has policies, procedures and processes in place to meet its obligations in relation to the Health and Disability Commissioner’s (HDC) Code of Health and Disability Consumers’ Rights (the Code). Staff were able to explain rights for residents in a way that promotes choice. The posters identifying residents’ rights are displayed in the facility. Staff receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the education programme, with this provided in 2017.  Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.  The auditors noted respectful attitudes towards residents on the days of the audit. Residents state they receive information relative to their needs, services which meet their needs and staff respect their wishes. |
| 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. | PA Low | The service information pack includes information regarding informed consent. The NM and RNs discuss informed consent processes with residents and their families during the admission process.  The informed consent policy and procedure includes guidelines for consent for resuscitation/advance directives and resuscitation orders. The service is using two forms that are both titled advanced directives, one being used to document advanced directives and the other to document resuscitation status. The forms were amended during the audit to reflect that the service differentiates between advanced directives and resuscitation status. This is yet to be implemented.  Informed consent forms do not include consent for outings. The informed consent policy and procedure guides staff in the process to obtain informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.  Resident files identified that informed consent is obtained. Interviews with staff confirmed their understanding of informed consent processes.  Improvement is required for informed consent forms to include outings and the correct forms are used for advanced directives and resuscitation status. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Resident information relating to advocacy services is available at the entrance to the facility and in information packs provided to residents and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Staff training regarding advocacy services was last provided in 2017.  Family and residents confirmed that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services. The consumer auditor interviewed four residents who confirmed this. |
| 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 | The service has an open visiting policy and residents may have visitors of their choice at any time. Families confirmed they could visit at any time and are always made to feel welcome.  Residents are encouraged to be involved in community activities and to maintain family and friend networks. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisation’s complaints policy and procedures are in line with the Code and include periods for responding to a complaint. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved. Complaint forms are available at the entrance of the facility. Staff, residents and family confirmed they knew the complaints process.  Evidence relating to each lodged complaint is held in the complaints folder and register. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner.  The NM is responsible for managing complaints and residents and family stated that these are dealt with as soon as they are identified. Residents and family members were able to describe their rights and advocacy services particularly in relation to the complaints process.  There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The nurse manager (NM) and/or the registered nurse (RN) discuss the Code with residents and their families on admission to the service. The posters identifying residents’ rights and advocacy services are displayed in the facility in te reo Māori and English. Resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. Information and discussion on the Code is also included on the residents and relatives meeting agenda.  The consumer auditor interviewed four residents, including one under the disability contract. The residents confirmed that they had been informed about the Code on admission. |
| 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. | PA Low | The service has a philosophy that promotes dignity, respect and quality of life. The residents’ personal belongings are used to decorate their rooms.  A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident. Health care assistants (HCA) report that they knock on bedroom doors prior to entering rooms and ensure doors are shut when cares are being given. This was observed on the days of the audit. Residents and families confirmed that residents’ privacy is respected. There are improvements required in regard to conversations being heard at the walk around handover.  The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in accident/incident reports reviewed in residents’ files. Residents, staff, family and the general practitioner confirmed that there was no evidence of abuse or neglect. Staff interviewed were aware of the need to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.  Resident files reviewed confirmed that cultural and/or spiritual values and individual preferences are identified. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The organisation has a cultural responsiveness policy which outlines the processes for working with people from other cultures. A Māori health plan outlines how to work with Māori and the relevance of the Treaty of Waitangi. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan.  Currently there are no Māori residents or staff who identify as Māori. There is specific form for Māori residents to complete on admission with questions pertaining to their cultural needs. There is a whānau room available to use. The Māori health plan (Te Hohipera a Lynton Lodge) is given to residents on admission and there is copy of the plan in the entrance foyer.  A review of residents’ files confirmed that specific cultural needs are identified in the residents’ care plans. The NM stated that a kaumātua can be accessed by the service to support staff on tikanga protocols and general advice. Staff are aware of the importance of whānau in the delivery of care for the Māori residents. |
| 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 | Staff and resident interviews confirmed there are choices for residents regarding their care and services. Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the residents’ cultural values and beliefs. The initial care plan, the long-term care plan and InterRAI assessment are based on this information.  The facility has access to DHB interpreting services when required. There is a multicultural staff mix who are able to translate for the current residents, for example Chinese, Samoan, Indian and Tongan residents. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The service implements policies and procedures based on good practice, current legislation and guidelines. Staff confirmed awareness of how to identify and manage discrimination, abuse and neglect, harassment and exploitation. Staff training includes discussion of the staff code of conduct and prevention of inappropriate care. There were no complaints recorded in the complaints register for the previous 12 months relating any form of discrimination.  Job descriptions include the responsibilities of position including ethical issues relevant to the role. Staff complete orientation and induction include recognition of discrimination, abuse and neglect. Staff confirmed their understanding of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Lynton Lodge Hospital implements policies to guide practice. The policies align with the Health and Disability Services Standards.  The organisation’s quality framework includes their internal audit programme. There is a training programme for all staff and all staff are encouraged to complete training.  Residents and families expressed a high level of satisfaction with the care delivered. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident/accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms. Family contact is recorded in residents’ files. Family confirmed that they are invited to the care planning meetings for their family member and can attend the residents’ meetings. Families confirmed they are well informed.  Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/EPOA of any accident/incident that occurs.  Residents sign an admission agreement on entry to the service. This provides information around what is paid for by the service and by the resident. The admission agreements reviewed were signed on the day of admission. Staff are familiar with how translating and interpreting services can be accessed. Residents interviewed by the consumer auditor confirmed that they are well informed about their care and environmental changes. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lynton Lodge Hospital is a privately owned company with two company directors who provide oversight and support for the nurse manager (NM). The organisation’s mission statement and philosophy are displayed at the entrance to the facility. The facility can provide care for up to 40 residents requiring hospital level care. During the audit there were 35 residents living at the facility requiring hospital level of care. All residents were hospital level care of which four residents identified as young people under 65 years, with physical disability on a chronic care long-term contract.  The NM has a current practising certificate and has worked as a RN in the service for 16 years, with 7 of those years in the management role. |
| 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 | There are appropriate systems in place to ensure the day-to-day operation of the service continues should the nurse manager be absent. The senior registered nurses are able to stand in when the nurse manager is absent and support is provided by the two company directors. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality improvement plan with quality objectives, including a quality and risk management plan and business plan was reviewed. These are used to guide the quality programme and include goals and objectives. Service delivery is monitored through: complaints management; review of incidents and accidents; surveillance of infections; pressure injuries; soft tissue/wounds; and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues completed for incidents and accidents, meeting minutes and internal audits.  Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hardcopy. New and revised policies are presented to staff to read and staff sign to evidence they have read and understood the new/revised policy.  Monthly staff meeting minutes including quality improvement; health and safety; infection control and these evidence communication with all staff around all aspects of quality improvement and risk management. There are resident meetings coordinated by the diversional therapist that keep residents informed of any changes. Staff report that they are kept informed of quality improvements. Family are invited to come to the resident meetings.  Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited as per the annual audit schedule. Family/resident and staff satisfaction surveys are completed as part of the audit programme and results collated. Survey results reflect the satisfaction of the residents, family and staff. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The NM is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police attending the facility, sentinel events, pressure injuries, infectious disease outbreaks and changes in key management roles.  Staff interviews and review of documentation evidence that staff document adverse, unplanned or untoward events on an accident/incident form which are signed off by the NM. Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand the adverse event reporting process and were able to describe the importance of recording near misses.  There have been no deaths referred to the coroner or essential notifications to Ministry of Health or district health board (DHB) since the last audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checking, criminal vetting, completed orientations and competency assessments.  Copies of annual practising certificates were reviewed for all staff that require them to practice and are current. The NM is responsible for the in-service education programme. Staff are supported to complete education via external education providers. Staff files reviewed demonstrate that competencies are current and annual training occurs. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.  An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The NM advised that staff are orientated when they commence employment. The entire orientation process, including completion of competencies, takes up to three months and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Staff confirmed they had completed an orientation, including competency assessments.  The facility has three InterRAI trained registered nurses. |
| 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 rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse cover is provided 24 hours a day. On-call after-hours RN support and advice is provided by the NM. Health care assistants interviewed reported there are adequate staff available and that they are able to get through their work. Residents are supervised in communal areas. There is at least one staff member with a current first aid certificate on each shift. Residents and family interviewed reported staff provide them with adequate care. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Resident information is entered in an accurate and timely manner into a register on the day of the resident’s admission. Resident files are integrated and recent resident information is located in residents' files. Resident files reviewed provided evidence that an entry into the residents’ clinical record includes the time of entry, the date and entries are dated.  Residents' information is stored securely in staff areas. Clinical notes are current and accessible to all clinical staff. Individual resident files demonstrated service integration. This included medical care interventions. Medication charts are in a separate folder with medication. The resident's national health index number, name, date of birth and GP are used as unique identifiers. Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information. |
| 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 | Entry processes into the service are recorded and implemented. The needs assessments are completed for four young people with disabilities and hospital level of care. The philosophy of the service is displayed in prominent areas in the foyer and communicated to residents, family and staff.  The organisational information pack is available to residents and their family and contains relevant information on the services at the facility. The residents' admission agreements evidenced resident and/or family sign off within the required timeframe. The admission agreement defines the scope of the service and includes contractual requirements. Relevant admission information is communicated to residents and their families, this was confirmed during interviews. |
| 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. There is open communication between services, the resident and the family. Appropriate information is supplied to the service or individual responsible for the ongoing management of the resident.  Referrals are documented in the residents’ progress notes. |
| 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. | PA Moderate | The medication management systems (with the exception of administration refer to 1.3.12.1) evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The drug registers evidenced weekly checks, however, there is no consistent evidence of two staff members signing out drugs for administration, where this is necessary by legislation. This is a requirement for improvement. Six monthly physical stocktakes are undertaken by the pharmacy. The medication fridge temperatures are conducted and recorded.  Although all staff authorised to administer medicines have current competencies, the competencies of the staff member who administered medicines on the first day of the audit needs review (refer to 1.3.12.1). This is a requirement for improvement. Administration records are maintained, as are specimen signatures. Staff education in medicine management is provided.  Hard copy medicine charts evidenced current residents' photo identification, legibility, as required (PRN) medication is identified for individual residents and correctly prescribed, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GP. The residents' medicine charts record all medicines a resident is taking (including name, dose, frequency and route to be given).  The service’s policies provide guidelines and processes for residents to self-administer medicines. At the time of the audit there were no residents who self-administered medicine at the facility. |
| 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 dietary assessments are completed on admission and each resident has a dietary profile developed. Residents’ food preferences, special diets and modified nutritional requirements are known to the chef and accommodated in the daily meal plan. Special equipment, to meet residents’ nutritional needs, was sighted.  Residents' files demonstrated monthly monitoring of individual residents’ weights and where there is evidence of weight-loss, residents’ weight is monitored more frequently. The residents who are identified with weight loss have short-term care plans in place with relevant interventions to monitor the weight loss and/or weight gain. Interviews with residents stated their satisfaction with the food service. Residents’ individual preferences are met and adequate food and fluids is provided.  Resident satisfaction with meals was verified during resident and family interviews, satisfaction surveys and resident meeting minutes. Fridge and food temperatures are monitored daily. Kitchen staff have all attended food safety training.  Food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. |
| 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 | Processes are in place to inform residents and family of the reasons why services had been declined, should this occur. Referral agencies are informed of the reasons for decline of entry. Residents and/or their family are referred to more appropriate services in the area.  The residents would be declined entry if not within the scope of the service or if a bed was not available. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Residents' needs, outcomes and goals are identified through the assessment process and recorded in the long-term care plans. InterRAI assessments are completed on within three weeks of admission (refer to 1.3.3.3). There are processes in place to seek information from a range of sources, for example: family; GP; specialists and the referrer. Policies and protocols are in place to ensure continuity of service delivery.  The residents' files evidence residents' discharge/transfer information from the DHB, where required. The service has appropriate resources and equipment. The assessments are conducted in a safe and appropriate environment, usually the resident’s room, including visits from the GP. Interviews with residents and family confirmed their involvement in the assessments, care planning, review, treatment and evaluations of care. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Residents’ long-term care plans are individualised, integrated and up to date. Recorded interventions reflect the risk assessments and the level of care required (see 2.2.2.1). InterRAI assessments are completed by RNs and inform long-term care plans. Short-term care plans are developed for the management of acute problems, when required (refer to 1.3.3.3), and signed off by the RN when problems are resolved.  Interviews with residents and family members confirmed they have input into their care planning and review. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents' long-term care plans evidence detailed interventions based on assessed needs, desired outcomes and goals of residents. GP documentation and records are current. Interviews with residents and families confirmed their/their relatives’ current care and treatments meet their needs (refer to 1.3.3.3). The service maintains family communication records in the residents’ files. The nursing progress notes and observation charts are maintained.  Staff confirmed they are familiar with the needs of the residents. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Interview with the diversional therapist (DT) confirmed the activities programmes meet the needs of the different service groups. The DT plans, records, implements and evaluates the activities programmes.  The service has one activities programme for all the residents with specific additional activities for the four younger people with disabilities. Regular exercises and outings are provided for those residents able to participate. The activity programmes includes input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations.  There are current, individualised activities care plans in residents’ files reviews. The residents’ activities attendance records are maintained. The residents’ meeting minutes evidenced residents’ involvement and consultation of the planned activities programme. |
| 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 progress notes. Long-term care plan evaluations, following reassessment to measure the degree of a resident’s response in relation to desired outcomes and goals consistently occur every six months. The service develops a short-term care plan for the management of short-term concerns/acute problems, for example: infections, wounds and falls (refer to 1.3.3.3).  Interviews verified residents and family are included and informed of 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 | The service has processes in place to provide opportunities for residents to choose when accessing or when being referred to other health and/or disability services. The family communication sheets, located in the residents’ files, confirmed family involvement. The service has an effective multidisciplinary team approach and progress notes record facilitation of choices to residents. |
| 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 | Documented processes for the management of waste and hazardous substances are in place and the hazard register is current. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.  There is provision and availability of personal protective clothing and equipment including; goggles/visors; gloves; aprons; footwear; and masks. During a tour of the facility, personal protective clothing and equipment was observed in areas where there were risks. |
| 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 is displayed. There have been no building modifications since the last audit. The service has a planned maintenance schedule implemented with an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually.  Interviews with staff and observation of the facility confirm there is adequate equipment including; pressure relieving mattresses; shower chairs; hoists and sensor alarm mats.  There are quiet areas throughout the facility for residents and visitors to meet providing privacy when required. There are internal courtyards and lawn areas with shade, seating and outdoor tables. Access into the service from the foyer is through touch pads and key pads are used to exit the unit. The service has a current environmental restraint policy that includes the rationale to have a secure environment. Residents and family were observed entering and exiting the building and confirmed that they were informed of the reasons for having a secure environment. Monthly fire checks include the secure front door, which opens automatically in the event of a fire. These processes meet legislative requirements. The consumer auditor interviewed residents who confirmed they are able to use the key pads for exit and entry. Visitors were observed to be able to access and exit the facility using the key pads. The key pad combination is displayed by the door. |
| 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. | PA Moderate | There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.  Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.  Residents and family members report that there are sufficient toilets and showers with some rooms with their own en-suite. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.  An improvement is required in the management of safe water temperature. |
| 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 | There is adequate personal space provided in all bedrooms to allow residents and staff to safely move around within the room. Equipment is sighted in rooms requiring this with sufficient space for both the equipment, for example; hoists, at least two staff and the resident. Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own.  There is room to store mobility aids, such as walking frames, in the bedroom safely during the day and night, if required. |
| 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 | The service has lounge and dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, when required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.  The dining areas have ample space for residents. |
| 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 | Laundry is completed on site, with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry. Laundry staff are required to return linen to the rooms. Residents and family members state that their family member’s laundry is managed satisfactorily. The laundry staff interviewed confirmed knowledge of their role, including management of any infectious linen.  There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. Cleaners were observed on the days of the audit keeping the cleaning trolley in sight. All chemicals are in appropriately labelled containers. Laundry chemicals are administered through a closed system which is managed by a chemical contractor company. Products are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The evacuation plan has been approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. All required fire equipment is sighted on the day of audit and all equipment had been checked within required timeframes.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including: food; water; blankets; emergency lighting and gas barbeques. A call bell system is in all residents’ rooms, resident toilets, and communal areas including the hallways and dining rooms. Residents and family state that there are prompt responses to call bells. There is always at least one staff member with a first aid certificate on duty.  External doors leading to the gardens are locked after sunset. Staff complete a check in the evening that confirms that security measures are in place. |
| 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 | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever possible. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature. Family and residents confirm that rooms are maintained at an appropriate 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 infection prevention and control policies and procedures manual provides information and resources to inform staff on infection prevention and control. Strategies are in place to prevent exposure of infections to others.  The responsibility for infection control is clearly defined and includes the responsibilities of the infection control committee; infection control nurse (ICN) and the infection control team.  There is a signed ICN job description outlining responsibilities of the position. The ICN is supported in their role by the NM, RNs and the infection control team. The ICN is a RN. |
| 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 ICN has access to relevant and current information, appropriate to the size and complexity of this service.  Infection control is an agenda item at the facility’s staff meetings, evidenced during review of meeting minutes and interviews with staff. The internal audit programme includes infection control audits to monitor the implementation of the infection control programme. |
| 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 control committee develop and review the IPC policies and procedures implemented. Policies are developed and reviewed regularly in consultation and with input from relevant staff and external specialists.  The infection control manual is up to date. Policies reflect current accepted good practice reflects relevant legislative requirements. The infection control manual is easily accessible to staff. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control education is provided to all staff, as part of their orientation and ongoing in-service education and training programme.  Interviews with staff confirmed that clinical staff identify situations where infection control education is required for a resident. The service also include annual infection control training for residents as part resident meetings. Staff confirm that one-on-one infection control education of residents occurs in an informal manner.  The infection control staff education and training is provided by the ICN.  The ICN has attended external education relating to infection prevention and control. Education sessions have evidence of staff attendance/participation and content of the presentations. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The ICN is responsible for the surveillance programme. Infection control surveillance occurs monthly with analysis of data and reported at staff quality meetings.  The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infections. Staff complete infection logs for all episodes of infections. Residents diagnosed with infections had a short-term care plan in place.  Interviews with staff reported they are made aware of infections through short-term care plans, progress notes, handover and verbal feedback from RNs and the NM. There has been no outbreaks since the previous audit.  The facility’s surveillance data is benchmarked externally. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Definitions of restraint and enabler use in is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is not consistently recorded in procedures (refer to 2.2.2.1). There were two residents at the facility using enablers and six using restraints during the days of the on-site audit. The approval process for enabler use is not consistently activated when a resident voluntarily requests an enabler (refer to 2.2.2.1).  Interviews with staff and staff records confirmed that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training is provided.  The service do not consistently maintain records of enabler or restraint use (refer to 2.2.2.1). |
| 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 NM and RNs, with input from the GP, are responsible for approving restraint use. Oversight of restraint use is the responsibility of restraint coordinator. The restraint coordinator is the NM. The responsibilities for this role are defined in the position description, sighted. The restraint coordinator has completed training in restraint minimisation and restraint management relevant to their role and was able communicate their knowledge relating to the restraint minimisation standard.  Restraints are authorised following assessment of the resident (refer to 2.2.2.1). Approval includes consultation with other members of the multidisciplinary team. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Moderate | Four enabler/restraints were reviewed during the on-site audit. There were two enablers and six restraints in use at the time of the on-site audit. The service maintains a current enabler/restraint register. The service do not currently have rigorous processes in place to ensure all enabler and restraint use is safe and/or appropriate.  Restraint assessment is not consistently completed prior to commencement of restraint. The clinical files of residents using restraint evidenced that not all restraint assessment authorisation and care plans are in place. There is a requirement for improvement relating to different aspects of enabler and restraint use. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Protocols guide staff in the safe use of restraint. Strategies are implemented prior to the use of restraint to prevent the resident from incurring injury, for example: the use of low beds and sensor mats.  Staff training and education in restraint use includes appropriate orientation and ongoing education. Evidence of ongoing education regarding restraint and challenging behaviours was evident. The restraint register is up to date and records all necessary information to provide an auditable trail of restraint events.  The health care assistants are responsible for monitoring and completing restraint forms, however, this is not consistently completed (refer to 2.2.2.1). |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Evaluation of restraint occurs through measuring relevant clinical key performance indicators, however, not all restraint evaluations were consistently completed (refer to 2.2.2.1).  Documentation was sighted in the progress notes of the residents regarding restraint related matters. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint meetings are held monthly. Audits relating to restraint use are conducted. |

# 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)** |
| Criterion 1.1.10.4  The service is able to demonstrate that written consent is obtained where required. | PA Low | The service includes several processes to ensure consent is obtained; including general consent for information collection, use and sharing; consent for treatment and consent for the use of photographs. It does not include consent for outings. During the on-site audit the director changed the admission agreement in their system to include consent for outings however this was not part of the admission agreements reviewed.  There is also evidence of consent being obtained around advanced directives and the resuscitation decision, however, the organisation uses two documents as the ‘advanced directive’ record. One of these records notes the resident’s wishes and is signed by the resident who is deemed competent. The other record notes the resuscitation recommendation of the general practitioner (GP), based on the clinical assessment of the resident, for those residents who are not able to make informed decisions or an advanced directive. During the on-site audit the manager amended the document names accordingly, however, the implementation of these amended documents is yet to occur. Resident records reviewed referred to advanced directives. | i) Six of six general consent records did not include consent for outings.  ii) Six of six admission agreements did not include consent for outings.  iii) Five of the six resuscitation recommendations made by the GP based on the clinical assessments of the residents advanced directives were completed on the advanced directive form. | i) Consent forms to include consent for outings.  ii) Admission agreements to include consent for outings.  iii) Advanced directives forms and the resuscitation recommendation forms to be clearly identified and signed by the appropriate person.  180 days |
| Criterion 1.1.3.1  The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times. | PA Low | Registered nurses deliver and receive handover from one shift to the next. This occurs via a walk around the unit, where residents are discussed verbally. This discussion was observed on both audit days to be audible to other residents and visitors in public areas. This is then followed up with the formal handover in the office. | Handovers are completed in public areas in the audible distance of other residents and visitors. The conversations could be easily overheard by the residents and visitors in the areas. | Handovers are required to be held in a manner that ensures resident privacy is maintained.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Twelve hard copy medication records of residents reviewed confirmed their system includes safe and appropriate prescribing, appropriate dispensing records, timely review of medicines, and appropriate storage, disposal, and medicine reconciliation of medicines.  Review of the drug register and during the physical medicines round in the facility the staff member responsible for administration of medicines did not consistently show processes that are in line with legislative requirements. | i) Review of the drug register did not consistently show two staff members signing the register as required by legislation when administering some medication.  ii) During the physical medicines round in the facility the staff member; a) did not use the prescription and administration sheet to guide practice; b) unidentified medicines was put aside for later administration; c) handled tablets/capsules inappropriately d) positioned residents for medication administration, without communicating this intent with the resident; e) omitted to observe successful administration of the medication. | Medicines management administration processes to be safe and appropriate and to comply with legislation, protocols, and guidelines.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Long-term care plans are in place and reflect the care needs of the residents. All residents had InterRAI assessments completed within three weeks of admission.  Both residents’ clinical files reviewed during tracer methodology did not have InterRAI re-assessments completed at discovery of the PIs. Short-term care plans were in place (wound care plans) but did not include specific information relating to the wound care regime, for example; the type of wound dressings, timeframes for review of the dressings; monitoring records with detail about the wound appearance; measurements; photographs; or evidence of improvement/deterioration of the wounds. Two of three PIs in the facility were not included in the wound care register. | i) The InterRAI re-assessment did not occur when the residents’ condition changed.  ii) Wound care did not include; the type of wound dressings; timeframes for review and evaluation of the wounds; monitoring evidence for all wounds; measurements of all wounds; photographic evidence of wounds; or evidence of all wounds being reflected in the wound care register. | i) InterRAI assessments to be reviewed when the condition of the resident changes.  ii) Wound care to be comprehensive, appropriate and all wounds to be included in the wound care register.  90 days |
| Criterion 1.4.3.1  There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use. | PA Moderate | A component of the monthly maintenance schedule is to check all the hot water outlets to ensure they are at a safe temperate for the residents and staff. The temperature is not documented as being checked, the auditor was informed that the temperatures are between 45 to 50 degrees. | i) Hot water temperatures are tested but not recorded.  ii) Hot water temperatures exceed 45 degrees. | i) Record all hot water temperatures when tested.  ii) Ensure hot water temperatures are within acceptable parameters to ensure resident safety.  90 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 | Two residents using enablers and two residents using restraints’ clinical files were reviewed for safe and appropriate enabler and restraint use.  Restraint assessments, consent, risks, monitoring, review and long-term care plans are not consistently completed for all residents using enablers/restraint. | i) One of two enabler assessments and consents were not completed.  ii) Two of two enabler risks were not identified during assessment.  iii) Two of two enabler risks and two of two restraint risks were not reflected in the long-term care plan.  iv) Two of two restraint monitoring forms were not completed.  v) Two of two enablers have not been reviewed for appropriateness of current use. | All enabler and restraint use to be aligned with requirements and good practice.  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.

|  |
| --- |
| No data to display |

End of the report.