

Rosaria Rest Home 2006 Limited - Rosaria 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](#).

The specifics of this audit included:

Legal entity: Rosaria Rest Home 2006 Limited

Premises audited: Rosaria Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 29 August 2017 End date: 30 August 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: 22

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Rosaria Rest Home provides rest home level care for up to 26 residents. The service is operated privately. The owner is the manager and he is supported by an assistant manager and a registered nurse who oversees all clinical aspects of the service. The registered nurse commenced in the role in May 2016 and the assistant manager commenced in October 2016.

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 members, management, staff, and a general practitioner. All residents at the time of audit were Chinese and for this reason an independent interpreter was used to conduct resident and staff interviews. Residents confirmed their needs are met.

The service had sixteen corrective actions in the previous audit which have all been addressed and closed off by the district health board. There is evidence that corrective actions are embedded into practice. This audit has identified nine areas of improvements relating to complaints management, policies and procedures, medication management, food services, biomedical equipment testing and restraint management.

Consumer rights

<p>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.</p>	<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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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 are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff were observed to 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.

There were no residents who identified as Māori at time of audit however the registered nurse interviewed stated that residents whom identified as Maori if admitted to the facility would have their needs met in a manner that respects their cultural values and beliefs. There was 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.

A complaints register is in place with documented complaints resolved promptly and effectively.

Organisational management

<p>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.</p>		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the owner/manager is regular and effective. A suitably qualified person manages the facility. The registered nurse (RN) has worked in health care overseas and gained New Zealand registration in November 2015.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures are developed by an off-site service and personalised to Rosaria Rest Home.

The appointment, orientation and management of staff is based on current good practice. The language and ethnic mix of staff reflect the current resident mix. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. 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 medium or high risk and/or unattained and of low risk.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/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 are 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 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. 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 low risk.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. 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 and attend regular fire drills. 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 low risk.

The organisation has policies and procedures that support the minimisation of restraint. No enablers and one restraint were in use at the time of audit. A comprehensive assessment, approval and monitoring process is identified in policy.

Six monthly quality reviews occur. Policy states that the use of enablers is voluntary for the safety of residents in response to individual requests.

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 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 facility. 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	42	0	4	4	0	0
Criteria	0	92	0	4	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
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	The registered nurse and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the residents' records. Staff were observed to gain consent for day to day care.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code written in Chinese, 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 manager was able to provide examples of when they would involve the support of the Advocacy Services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>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.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Moderate	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that five verbal complaints and one written complaint had been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible.</p> <p>All complaints are discussed at staff meetings. One complaint discussed was not recorded in the complaints register sighted.</p> <p>The registered nurse, assistant manager and manager are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, from discussion with staff and in the admission agreement. The Code is displayed</p>

Consumers are informed of their rights.		in the main foyer areas in Chinese, English and Maori 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	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room, or share a room with their spouse.</p> <p>Residents are encouraged to maintain their independence by partaking in community activities and clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
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 interviewed discussed the importance of supporting residents in the service who identify as Māori to integrate their cultural values and beliefs and the principles of the Treaty of Waitangi into every day to day practice. There were no Maori residents who affiliate with their Maori culture at the time of audit, however the staff interviewed acknowledged and respected individual cultural needs. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available, should it be required.
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	All residents at time of audit identified with their Chinese culture. Residents verified that they were consulted on their individual culture, language, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed and interviews with residents and family. The resident 2016 satisfaction survey confirmed that individual needs are being met.

<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. The registered nurse has 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.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, however not all policies and procedures in use were up to date (see criterion 1.2.3.3). Access to and input from external specialist services and allied health professionals is available, for example, hospice/palliative care team, a psychogeriatrician and mental health services for older persons. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/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 is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to staff being able to provide interpretation on a one to one basis, via phone and video link and as and when needed, and through the use of family members.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A sample of monthly reports which are shared with the owner/manager and staff showed adequate information to monitor performance is reported including financial performance, emerging risks and issues.</p>

		<p>The service is managed by the owner who holds relevant qualifications and has been in the role for six years. He has owned the facility for over 10 years. There is an assistant manager who helps with non-clinical areas and a registered nurse who oversees all clinical aspects of care. Responsibilities and accountabilities are defined in a job descriptions and individual employment agreements. The registered nurse and owner manager confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through ongoing education.</p> <p>The service holds a contract with Auckland District Health Board (ADHB) for Age Related Residential Care. All 22 residents were under the ADHB Age Related Residential Care contract.</p> <p>There are three boarders at the time of audit. They are all relatives of residents and pay privately.</p>
<p>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.</p>	FA	<p>When the owner/manager is absent, the assistant manager and the registered nurse carry out all the required duties under delegated authority. During absences of the registered nurse, the clinical management is overseen by a casual RN who previously held the RN role at the facility. They are able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>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.</p>	PA Moderate	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, monitoring of outcomes, and clinical incidents including infections and wounds. The registered nurse and owner/manager have a good understanding of what is required and undertake the tasks of reporting, analysing and trending against other previously collected data. Results are used to improve care as appropriate.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings which is attended by members of management. Staff reported their involvement in quality and risk management activities through audit activities and implementing corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction is measured during monthly residents' meetings and regular family contact as confirmed in minutes sighted and during resident and family interviews. All comments received on the days of audit were positive.</p>

		<p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies have been developed by an off-site company and were personalised to Rosaria Rest Home. Not all policies and procedures sighted in hard copy were the most current version.</p> <p>The owner/manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The owner/manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>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.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owner/manager and at all staff meetings.</p> <p>The registered nurse described essential notification reporting requirements, including for pressure injuries. The owner/manager and registered nurse advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit.</p>
<p>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.</p>	FA	<p>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.</p> <p>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 show documentation of completed orientation and a performance review after a 12-month period.</p> <p>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 trained and competent to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>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. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Observations and review of four weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>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.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The facility does not have an information pack for new and or potential new residents and their families; however, the facility manager/owner stated that this is to be implemented.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>

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 co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/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 appropriate documentation and communication. 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.	PA Moderate	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management 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. All staff who administer medicines 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 on request. Controlled drugs, when on site, are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drugs register evidenced no controlled drugs on site since June 2016. 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; however, not all requirements for pro re nata (PRN) medicines and residents taking vitamins and other non-prescribed items were met. The required three-monthly GP review is consistently recorded on the medicine chart. There were four residents self-administering medications at the time of audit. Not all required processes were in place to ensure this was managed in a safe manner. 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.	PA Moderate	<p>The food service is provided on site by one of two cooks, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>Aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines; however, there was no documented evidence that the cleaning schedule is being implemented. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The temperatures and contents of seven residents' fridges were not being monitored. The cook has undertaken safe food handling training, with care staff also completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, 2016 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.</p>
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 NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of when this situation would occur were discussed. 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	FA	Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. 20 of 22 residents have current interRAI assessments

in a timely manner.		completed by one trained interRAI assessor on site and two remaining residents have interRAI assessments commenced but in draft. Residents and families confirmed their involvement in the assessment process.
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>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.</p> <p>Care plans evidence service integration with progress notes, activities notes, 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.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders were followed, and care was 'excellent'. 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.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by an activity co-ordinator. 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 monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys. Residents interviewed confirmed they find the programme very interactive and stimulating.</p>

<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months 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. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, falls and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>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.</p>	FA	<p>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 rheumatology, endocrinology and the hospice. 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.</p>
<p>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.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Cleaning products have material safety data sheets and staff receive safe chemical handling education. Staff interviewed verbalised their understanding of what to do should any chemical spill occur. Chemicals are securely stored.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>A current building warrant of fitness (expiry date 22 June 2018) was publicly displayed.</p> <p>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 is current but calibration of bio medical equipment was overdue, as confirmed in documentation reviewed. The environment was hazard free, residents were safe and</p>

		<p>independence was promoted.</p> <p>External areas are safely maintained and were appropriate to the resident group and setting.</p> <p>Staff confirmed they knew the processes they should follow if any repairs or maintenance is required. Residents interviewed were very happy with the environment.</p>
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	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes three bedrooms with toilet and hand basin ensuites and one bedroom with a full ensuite. All bedrooms have hand basins. Appropriately secured handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Toilet and bathroom areas have been upgraded since the previous audit.</p>
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	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are four bedrooms which can be used as double rooms. There are three married couples in three of the bedrooms and one is used as a single room. The owner/manager stated only couples who request a double room are placed in the double bedrooms. This was confirmed during resident, staff and family interviews. The other bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids and wheel chairs. Staff and residents reported the adequacy of bedrooms.</p>
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	<p>Communal areas are available for residents to engage in activities. There are two dining areas, one is also a lounge area with the area divided by furnishings. Dining and lounge areas enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. This was confirmed during resident and family interviews.</p>
Standard 1.4.6: Cleaning And Laundry Services	FA	<p>Laundry is undertaken on site in a dedicated laundry. New washing machines and a dryer have been purchased since the previous audit. Laundry and cleaning is undertaken as part</p>

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>of the caregivers' duties. Residents and relatives confirmed they were happy with the services provided and that the facility is kept clean and tidy.</p> <p>Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>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 on the 3 October 2002. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service; the most recent being on 13 June 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets and gas BBQ's were sighted and meet the requirements for the 26 residents. A water storage tank is located in the basement. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at as part of the afternoon shift duties by staff. Staff and residents stated they feel safe at all times.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside deck areas. Heating is provided by gas in communal areas and electricity in residents' rooms. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers,</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from an external source as</p>

<p>service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>required. The infection control programme and manual are reviewed annually. 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 monthly at staff meetings and to the facility manager/owner. 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.</p>
<p>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.</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role since June 2016. She is currently undertaking training in infection prevention and control. 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.</p> <p>At the time of audit an outbreak infection kit was being developed. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>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.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers,</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by a suitably qualified registered nurse/IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of</p>

support staff, and consumers.		<p>attendance is maintained. When an increase in infection incidence has occurred, there was evidence that additional staff education had been provided in response.</p> <p>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.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year and comparisons against previous years, and this is reported to staff and the facility manager/owner. Infection rates remain low for the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the registered nurse who had partial understanding of the organisation's policies, procedures and practice. Refer to comments throughout the standard.</p> <p>On the day of audit, one resident was using restraint (bedside rail) and no residents were using enablers. Policy states that enablers are the least restrictive and used voluntarily at the resident's request.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p>	FA	<p>The restraint approval group, made up of the registered nurse, owner/manager and the GP, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, the file of the one resident</p>

<p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>using restraint, and interviews with the coordinator, that the restraint in place was requested by family of the resident for safety reasons only.</p> <p>Evidence of family/whānau/EPOA and resident involvement in the decision-making process was clearly documented.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	PA Low	<p>The restraint assessment requirements are clearly identified in policy. The assessment form shown in the restraint policy was not used prior to the bedside rails being put in place for the one resident using these as a restraint. The restraint coordinator did not clearly understand the need for assessment as this was requested by the family. The general practitioner is involved in the final decision on the safety of the use of the restraint and this was shown in the restraint approval group review sighted.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Low	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, such as the use of sensor mats. This process has been well documented related to a resident who had two falls in a month. Since a sensor mat has been introduced four months ago no falls have been recorded.</p> <p>For the bedside rail restraint in use at the time of audit, no documented monitoring had occurred. The RN and staff confirmed they check the resident regularly, but this is not documented. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>The restraint register, review group meeting minutes and the staff meeting minutes identify that only the current bedside rails have been used since the previous audit. The bedside rails were commenced in February 2017. The register was reviewed and contained the resident currently using a restraint and sufficient information to provide an auditable record.</p> <p>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 understood that the use of restraint is to be minimised.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of the resident's file showed that the individual use of restraints was reviewed and evaluated during the resident's care planning updates and this was documented in the restraint approval group six-monthly meeting minutes and discussed at monthly staff</p>

		meetings. Family approval was documented. The restraint approval group evaluation identifies that no adverse events have occurred since restraint had been in use.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	PA Low	<p>The restraint committee undertakes a six-monthly review of all restraint use. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the staff meetings. The restraint committee meeting minutes reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, restraint / enabler education and feedback from the doctor, staff and families. However, policy and procedures are not reviewed.</p> <p>Data reviewed, minutes and interviews with staff and management confirmed that the use of restraint commenced in February 2017 for one resident, following the request of family to ensure their relatives safety.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Moderate	There is a complaint register in place. Follow up actions are documented with dates shown. All complaints are discussed at staff meetings. Meeting minutes reviewed showed that one complaint discussed was not recorded in the complaints register. The owner/manager was able to verbalise actions taken and gave assurance the issue had been reviewed, addressed and was closed. The previous audit identified an issue related to the complaints register not being in place.	One complaint identified in staff meeting minutes is not recorded in the complaints register.	Provide evidence that all complaints are recorded in the complaints register. 30 days
Criterion 1.2.3.4 There is a document control system to manage	PA Moderate	Policies and procedures are provided by an off-site provider and are aligned with current good	The hardcopy of policies and	Provide evidence that

<p>the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>		<p>practice, meet legislative requirements, and are reviewed and sent to the provider at least two yearly. Rosaria Rest Home personalise the documents and keep a hard copy folder in the nurses' office. The electronic version is replaced by the owner/manager. However, not all hardcopy policies and procedures were up to date. This occurred for large document downloads such as infection control. The registered nurse and the owner/manager have access to these documents electronically but they have not been printed to update the paper version available to all staff.</p>	<p>procedures used by staff is not well maintained to show the up to date version of policies and procedures.</p>	<p>all hardcopy polices and procedure are up to date. 30 days</p>
<p>Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>Four residents had an assessment completed to assess for competency of self-administration of medication. The assessments were signed by the admitting RN and GP at the time, and subsequent assessments have been completed annually. The RN has evidenced that the resident is asked weekly if they have taken their medication and this was recorded. In discussions with the residents and staff, it was evident that the residents are competent in the self-administering of their medication and evidence was provided to show three-monthly GP reviews that included review of the resident's medication. Observation on day one of the audit, showed that the residents were storing their medication in unlocked draws in their rooms. On day two of the audit all four residents had their medications stored in locked boxes in their rooms. The residents were also evidenced to be taking vitamins and other non-prescribed items.</p>	<p>Four residents are self-administering medication. Policy states resident's competency to continue self-medication should be documented three-monthly, but this is completed yearly. Staff checks were undertaken weekly and policy states this should occur daily. Residents' medications were not stored in a locked and secure location in their bedrooms on day one of the audit. Residents were self-administering vitamins and other non-prescribed items.</p>	<p>Provide evidence that all residents whom are self-administering are meeting the facility policy requirements. 30 days</p>

Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	The registered nurse was able to provide evidence of indications why a pro re nata (PRN) medication was administered and its effects/outcomes for the resident. Residents interviewed stated that they were happy with the support provided by the GP. Evidence was provided to show three-monthly GP reviews that included review of resident's medication and use however 14 of 22 residents had pro re nata (PRN) medicines charted with no indication for use shown.	Not all residents who had pro re nata (PRN) medicines charted by the GP had written indications for use shown.	Provide evidence that all medication charting complies with legislation and guidelines. 30 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Moderate	The facility has a very low infection rate and on observation the kitchen appeared clean. The residents and families interviewed stated that they were very happy with the meals provided. The cook interviewed stated that they clean the kitchen on a daily basis and was able to show evidence of a cleaning schedule; however, there was no evidence that the schedule was being implemented. Seven residents had small fridges in their rooms and one resident's fridge was located in the dining room. The residents interviewed stated that they had no concerns and on observation there was no spoiled and/or expired food that the residents held in their fridges, there was no evidence to show monitoring of the resident's fridge temperatures and/or regular cleaning of the resident's fridges and checking of expired foods. This is an ongoing issue and was also a finding in the previous audit.	There is no documented evidence that the cleaning schedule in the kitchen is being implemented. Temperatures and contents of seven resident fridges are not being monitored.	Provide evidence that all a cleaning schedule is maintained in the kitchen. Provide evidence that resident's fridges are monitored to comply with safe food hygiene and correct temperatures are maintained. 30 days

<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>Electrical equipment is checked and the register identifies that the next checks are due in July 2018. The physical environment is well maintained and there is a documented upgrade plan in place. Regular day to day maintenance is undertaken by the manager and/or contractors as appropriate. The calibration of bio medical equipment was overdue. The facility has purchased stand on weigh scales within the last 12 months.</p>	<p>Biomedical equipment testing was due in 2015 and this includes two blood pressure cuffs and sphygmomanometers and two stethoscopes.</p>	<p>Provide evidence that biomedical equipment testing has been undertaken as required.</p> <p>180 days</p>
<p>Criterion 2.2.2.1</p> <p>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:</p> <ul style="list-style-type: none"> (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 Low	<p>Policy and procedure contains all required assessment forms and guidance for staff. The assessment form sighted identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. An assessment form was completed at the time of audit covering all the requirements for the resident using bedside rails as a restraint. The desired outcome was to ensure the resident's safety. A review of the resident's file identified there have been no falls or concerns since the bedside rail has been in use.</p>	<p>The resident with a beside rail in place as restraint did not have an assessment completed prior to audit.</p>	<p>Provide evidence that the correct restraint assessment procedure is followed to meet policy requirements and that this process is embedded into practice for any restraint use.</p> <p>180 days</p>

<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <ul style="list-style-type: none"> (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. 	PA Low	<p>Policy and procedure are in place with a specific monitoring requirements form; however, no monitoring had occurred prior to audit for the one resident using a restraint. A monitoring form was put in place at the time of audit appropriate to the risk identified. Staff confirmed they understood the form and that the two hourly checking requirements would be documented.</p>	<p>No documented monitoring of restraint had occurred for the one resident using a restraint.</p>	<p>Provide evidence that monitoring of restraint use is undertaken according to the assessed level of risk and that this is embedded into practice in the future.</p> <p>60 days</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <ul style="list-style-type: none"> (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 	PA Low	<p>The service undertakes a six-monthly restraint review meeting, which is clearly documented. The type and number of restraints in use are discussed and reviewed. The review does not include policy and procedures to ensure compliance is not occurring. The reviews identified that no adverse events had occurred as the result of restraint use.</p>	<p>The six-monthly review process does not cover all required aspect of review as shown in policy. It is clear that policy and procedures have not been reviewed for compliance.</p>	<p>Provide evidence that the six-monthly quality reviews of restraint include policy and procedure review to ensure all aspects of policy are</p>

<p>service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>				<p>being followed.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.