Heritage Lifecare Limited - Granger House Lifecare

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Granger House Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 October 2017 End date: 27 October 2017

Proposed changes to current services (if any): This provisional audit was completed with the agreement of HealthCERT by using the certification audit report completed in August 2017 and undertaking the provisional audit interview requirements with the prospective provider.

Total beds occupied across all premises included in the audit on the first day of the audit: 56

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.

General overview of the audit

Granger House and Richard Seddon Hospital provide rest home and hospital level care for up to 70 residents. The service is owned by Kiwiannia Care Limited, which is currently in receivership, and is managed by a facility nurse manager and a clinical nurse leader. Residents and families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included the certification audit completed in August 2017, which involved review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, two district nurses, a nurse practitioner and a general practitioner. The receiver was also on site during the certification audit in August 2017.

In October 2017 an interview with the prospective provider was conducted in a process agreed with HealthCERT.

At the August certification audit significant improvements were seen in a number of the areas identified as requiring improvement in the last audit which had been conducted in January 2017.

Areas requiring improvements identified during the August 2017 audit related to staff training, resident assessments, nutrition and food safety, and review of restraint. None of these are high risk.

No additional areas for improvement were identified through the interview with the prospective owner in this October 2017 process.

Consumer rights

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 interact with residents in a respectful manner.

The prospective owners, Heritage Lifecare Limited (HLL), are existing providers in the sector. They have experience and knowledge of the Code and understand their responsibilities for ensuring residents' rights are met through service provision.

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There 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 individual needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Business and quality assurance and risk management plans (2017-2018) include the business objectives, values and mission statement of the organisation. Monitoring of the services provided to the receiver is now regular and effective. An experienced and suitably qualified person was appointed in May this year to manage the facility.

The quality and risk management system now includes collection and analysis of quality improvement data, identifies trends and leads to improvements being made. 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 support service delivery, were current and are now being reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. A process is currently being put in place to ensure all staff are attending the required training. Staffing levels and skill mix meet the changing needs of residents.

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

The prospective owner has a detailed transition plan to manage the process of the potential sale and transfer of ownership. The plan includes identification and management of risks. No changes are planned for the immediate future.

Continuum of service delivery

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

The 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 safely managed and administered by staff that 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

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical compliance testing is now being undertaken appropriately.

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.

The prospective owner is not planning any structural changes to the facility in the immediate future.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Six enablers and six restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process, with regular reviews, occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

The prospective owner understands their responsibilities for restraint minimisation and safe practice and supporting residents to use enabling equipment.

Infection prevention and control

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

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	46	0	2	2	0	0
Criteria	0	96	0	3	2	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	Kiwianna Care Limited has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed 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 resident's record. Staff were observed to gain consent

		for day to day care.
Standard 1.1.11: Advocacy And Support

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources

Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.

The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management

The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Forms are also available at reception.

The complaints register reviewed is now maintained both electronically and in hard copy. It showed that 17 complaints have been received and documented over the past six months and that actions taken, through to an agreed resolution, are completed within the timeframes. Action plans showed any required follow-up and improvements have been made where possible. There have been no new complaints received since mid-June. The facility nurse manager is 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 the Health and Disability Commissioner's office or the office of the Coroner since the |

		previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, and in discussion with management on admission. The Code is displayed in the entrance to the facility and communal areas together with information on advocacy services, how to make a complaint and feedback forms. The prospective owner, Heritage Lifecare Limited, are an established provider of aged residential care services. They understand their responsibilities for providing information to residents on the Code and ensuring staff receive training.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room, or share a room with their spouse, with their consent. Residents are encouraged to maintain their independence by attending community activities, participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
Standard 1.1.4: Recognition Of Māori Values And Beliefs	FA	Staff support residents in the service who identify as Māori to integrate

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.		their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. There were no residents at the time of the audit who identified as Maori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed (eg, one resident who prefers to have ministers visit them in their room, rather than as part of the weekly group). The resident satisfaction survey confirmed that individual needs were being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, wound care specialist, district nursing team, mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. He was particularly complimentary of the skill and knowledge of the current facility nurse manager and clinical nurse

		manager.
		Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
		Other examples of good practice observed during the audit included full implementation of an external consultant's policies, procedures and electronic risk system.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff knew how to access interpreter services, although reported this was rarely required due to most residents being able to speak English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic and business plans were reviewed last month and they are now in a regular review cycle. They outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. These are available for all staff to access. A sample of the regular reporting to the receiver showed adequate information to monitor performance is reported including financial performance, emerging risks and issues. The current management structure with reporting lines clearly defined is in place. A decision has been made by management not to enter into a palliative care contract or accept any referrals for this service until such time as adequate staffing and relevant training processes have been implemented. The service is managed by a facility nurse manager who holds relevant qualifications, has significant recent experience in the health and disability sector and has been in the role for three months.

		Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains current competencies through the Nursing Council of New Zealand. She has, and will continue to, undertake relevant management and business training.
		The service holds contracts with the DHB for aged residential and respite care and the MoH for YPD – residential non-age care. 56 residents were receiving services under the contracts (17 rest home, 38 hospital level, one MoH resident) at the time of audit.
		The prospective owners, Heritage Lifecare Limited (HLL), provide aged related services and management services in other locations throughout New Zealand. They understand the contracts the present owner has with the DHB and Ministry of Health. HLL's senior quality and compliance manager was interviewed and provided evidence of HLL's transition plan which has been developed following their template planning process. Regular transition meetings are held to monitor progress and responsibilities to be completed within set timeframes.
		HLL has contacted the funders and notified them of their intention to purchase the facility, pending the outcome of their pre-sale due diligence process. They have also arranged meetings with the funders to occur in the week following the provisional audit interview.
		No changes are planned to the registered nurse full time equivalents or structure of the organisation.
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	When the facility nurse manager is absent, the clinical nurse leader carries out all the required duties under delegated authority. This is clearly documented in clinical nurse leader's job description. During absences of key clinical staff, the clinical management is overseen by the facility nurse manager, who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Once the current registered nurses gain more experience in relevant clinical management practice, the clinical oversight during absences will be re-

		evaluated. Staff reported the current arrangements work well.
		HLL are not planning to make any changes to the facility manager or clinical manager positions.
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	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. Over the three months prior to the audit, the collection, analysis and collation of data had strengthened the quality and risk management system. This includes management of incidents and complaints, audit activities, regular resident and family meetings and surveys, and clinical incidents including infections and medication errors. The facility nurse manager, supported by the clinical nurse leader, takes responsibility for the implementation and monitoring of the quality programme. Recent meeting minutes reviewed confirmed regular review and analysis of quality indicators is now in place and that related information is reported and discussed at the management meetings with the receiver, clinical team and quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, during staff meetings and that all quality team meeting minutes are made available to them. Relevant corrective actions are now being developed and implemented to address any shortfalls. Resident and family satisfaction surveys will be completed at least annually as is documented in the quality programme. A number of topic specific surveys have been recently completed. The most recent survey showed the residents felt there was a lack of choice for the evening meals. In response to this feedback, a new menu is currently out for discussion and feedback. Families also requested better communication processes and this has resulted in a regular monthly newsletter, the activities programme circulated and families informed of all external resident appointments prior to them occurring. There are also more frequent family meetings which are now being held two-monthly. 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 are

based on best practice and were current. The new document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff are required to read and implement all current and any new policies and procedures. A new "quiz" programme has been introduced to monitor staff knowledge of these.

The facility nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies that are now being implemented. These processes were reviewed during the audit and demonstrated a comprehensive system is now in place. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.

HLL has their own quality and risk management plan and system. Their acquisition process includes a gradual process of replacing the new facility's systems and procedures with HLL's. Management and clinical indicator reports will be implemented first. Other policies, procedures and forms will be implemented gradually over time to ensure this is effective and meets the needs of staff members. These activities are included in the transition plan.

Standard 1.2.4: Adverse Event Reporting	FA	Staff document adverse and near miss events on an incident form. These are then loaded onto the electronic quality management system. A sample of incidents forms reviewed from the past three months 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 receiver, the quality team meetings as well as to all staff at their regular meetings.
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.		
		The facility nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of a significant event made to the public health service since the previous audit.
		The senior quality and compliance manager stated that there are no legislative or compliance issues which HLL would need to manage if the sale is successful. They reported that they are unaware of any

		significant events having occurred since the last onsite audit in August 2017.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are now being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process now in place, prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period. Continuing education is planned on an annual basis, including mandatory training requirements. A number, but not all, 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. A staff member is the internal assessor for the programme and work is continuing with Careerforce to embed this training. There are sufficient trained and competent registered nurses who are maintaining or completing their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). 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 interviewed supported this. Observations and review of a two-week roster cycle confirmed there is now sufficient staff cover being

		provided, with staff replaced in any unplanned absence from a casual pool. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage in the hospital. The night shift has a RN and two health care assistants (HCAs) cover in the hospital and a RN or EN (enrolled nurse) and a HCA in the rest home. Current staffing numbers provide more than the required levels and skill mix for the current residents.
		HLL has their own policy for the provision of safe staffing in its facilities. This is based on the Indicators for Safe Aged Care and Dementia Care for Consumers Handbook. These indicators and HLL's policy provide for staff having first aid certificates, appropriate ongoing training and 24/7 registered nursing staff for residents receiving hospital level care.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local 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 organisation seeks updated information from the NASC, GP and families for residents accessing respite care.

		Family members and residents interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
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 a documented paper system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information 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 all documentation was completed and the family informed throughout.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy 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 using a blister pack system was observed on the days of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All 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 monthly on request. All medications in use are recorded accurately and signed as administered including topical medications and insulin. Controlled drugs are stored securely in accordance with requirements

		and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.
		The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.
		Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are used, were current and complied with guidelines.
		There were no residents self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner, should this be required.
		There was 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	The food service is provided on site by a cook and kitchen team, and follows summer and winter patterns and has been sent for review to a dietitian. However, the menu in use has not been approved by a dietitian.
		All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded. Food storage is not in line with recommended guidelines and the cook and kitchen staff have not undertaken a safe food handling qualification.
		A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed, however these are not always followed by the serving staff. 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, is available.

		Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local 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 this occurring 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 in a timely manner.	PA Moderate	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, continence assessment and nutritional screening (two forms), as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by three of five RNs, as trained interRAI assessors on site. While there has been significant improvement in addressing overdue interRAI assessments with the new management team, there are still overdue interRAI assessments and the interRAI is not being used as the primary assessment tool. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed mostly reflected the support needs of residents (refer criterion 1.3.4.2), 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.
		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. This was observed during a handover of shifts. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is delivered to a very good standard. He is available at all times for staff to contact him and he confirms this happens often. He was complimentary of the new management team. 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.
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	A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the

		programme varied and enjoyable, but they do not have to attend.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, assessment tools, 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, wounds, and falls. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Residents may choose to use their own 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 geriatrician, speech language therapist, and dietitian. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur with spill kits sighted

| | | around the facility.

There is provision and availability of protective clothing and equipment and staff were observed using this. |
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| Standard 1.4.2: Facility Specifications

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 1 July 2018) is publicly displayed.

Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of biomedical equipment is now current as was confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted. A comprehensive maintenance programme is in place and being implemented.

External areas are safely maintained and are appropriate to the resident groups and setting. Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.

HLL are not intending to make structural changes to the facility. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 25 rooms with shared ensuites, another ten showers and 14 toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. |
| Standard 1.4.4: Personal Space/Bed Areas

Consumers are provided with adequate personal space/bed areas | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation except for a married couple who share a room |

appropriate to the consumer group and setting.		and who also have their own lounge area. Rooms are personalised with furnishings, photos and other personal items displayed.

There is adequate room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Each wing has its own dining and lounge areas. These are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. A large communal area is available for residents to engage in the activities programme. |
| 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 undertaken on site in a large dedicated laundry area or by family members if requested. There are also two smaller laundries where residents and/or families may do smaller personal items. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.

There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable room and were in appropriately labelled containers.

Cleaning and laundry processes are monitored through the internal audit programme and staff spoken with demonstrated a clear understanding and knowledge of their respective roles and the safe handling of all products in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems

Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency.   The current fire evacuation plan was approved by the |

		New Zealand Fire Service on the 12 April 2012. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 11 July 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.
		Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, headlamps, torches, tools, ropes and gas cookers were sighted and meet the requirements for the 56 residents. Water storage containers are located in the maintenance area and there is a generator on site. Emergency lighting is regularly tested.
		Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells and during the audit these were observed to be answered promptly.
		Appropriate security arrangements are in place. Doors and windows are checked and locked at a predetermined time.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and all have opening external windows Heating is provided by electric heaters in residents' rooms and large wall heaters provide heating in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the local hospital as required. The infection control programme and manual are reviewed annually. The clinical nurse manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to

		the facility nurse manager, and tabled at the quality/risk committee meeting. This committee includes the facility nurse manager, the health and safety officer, and representatives from food services and household management. A report is provided to the receiver.
		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.
		During a recent outbreak, visitors were kept away with clear signage on entry to the facility.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for three months. She has not yet undertaken relevant training (refer criterion 1.2.7.5). Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection, which occurred recently. This was effectively managed with the resources in place.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in June 2017 and include appropriate referencing. 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.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when a gastro-intestinal outbreak occurred. The IPC RN co-ordinator and facility nurse manager developed a quiz for staff following the outbreak to gain feedback on effectiveness of training, information and staff awareness. They plan to use this to improve systems. 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, including during the outbreak.
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	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 are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. 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 reported to the facility nurse manager, and quality committee. Data is benchmarked externally with other aged care providers using an external risk management system. This ensures that infections are not above average for the service. A summary report for a recent gastrointestinal infection outbreak was

		reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event are now being analysed following feedback from staff.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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 provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. (Refer criterion 1.2.7.5) On the day of audit, six residents were using restraints and six residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group/quality team minutes, files reviewed, and from interviews with staff. HLL have appropriate policies and procedures to guide the use of restraints and enablers. Policies focus on the minimisation of restraint use and provide processes for the assessment, implementation and monitoring of enablers when these are requested by residents. Both enablers and restraints are reported through monthly clinical indicator reporting by each facility in the HLL group. As noted in Standard 1.2.3, this reporting will be implemented soon after the transfer of ownership, if the sale is successful.
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	FA	The restraint approval group, made up of the restraint coordinator who is currently the clinical nurse leader, a RN and the resident's general practitioner. They are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval records, which are also discussed as a part of the quality team meetings, the restraint register, residents' files and

and others.		interviews with the coordinator, that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and will be analysed when sufficient information is available. Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint. These were all current.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members including the use of sensor mats and low beds. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record. 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 and how to maintain safety when in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, and at the restraint approval group/quality team meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	PA Low	The restraint committee has not yet undertaken a six-monthly review of all restraint use. This is due to the lack of data available prior to the new management implementing regular reporting. Data is now being collected and entered into the quality system to allow monitoring and quality reviews within the service to take place when planned in November of this year.

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 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	While an annual training programme and individual training records are now in place, there is no ongoing monitoring process implemented yet to ensure staff are attending the programmes as planned. The files reviewed showed staff had attended some training in the last six months, but not everyone had attended all of the required sessions. A new process is currently being implemented which will involve individual follow-up by the facility nurse manager for each staff member who has missed a core training session without an acceptable reason. They are then expected to ensure they complete the training as soon as possible. However, to date not all staff have either commenced or completed the	There is no evidence that all current staff have attended the required core training this year. End of life care training has yet to be completed by all relevant staff and external training has not been completed by the clinical nurse leader who is the restraint and IPC coordinator. Not all staff have either commenced or completed the required foundation skills training specified in the Aged Residential Care (ARC) Contract.	Ensure all staff have either commenced or completed the required foundation skills training specified in the ARC contract. Implement the planned monitoring process to ensure all current staff attend the required core training programmes that are included in the annual training plan. Ensure end of life training goes ahead as planned and external training is put in place for the IPC and restraint coordinator. 90 days

| | | required foundation skills training specified in the Aged Residential Care Contract.

While there are no palliative care residents or contract in place, there are residents who do require end of life care. Training is now planned, and will occur in August. In addition, external training for the clinical nurse leader in infection prevention and control (IPC) and restraint has not been completed. | | |
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| Criterion 1.3.13.1

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | The current menu follows a summer and winter pattern and has been updated from the previous menu, with changes identified following a residents' meeting. Residents did not like many items on the menu and asked for different options to be added. In response to this feedback, an amended version was sent to the dietitian and while this menu is being used it has not been approved by a dietitian. Evidence was provided that this has been emailed to her. Residents and family interviewed confirmed satisfaction with the current menu.

While the cook and kitchen staff prepare/cook food for residents' tea meals, the rest home care staff serve the food and they are not always aware of the residents preferences. Therefore nutritional profiles are not routinely being met, | Food preparation is not currently being undertaken according to a dietitian approved menu. Residents' nutritional profiles are not always being followed. | Food, fluid and nutritional needs of the residents are provided according to input from a dietitian, and an approved safety plan, to ensure these are in line with recognised nutritional guidelines.

90 days |

		for example one resident with egg intolerance was provided with egg sandwiches.		
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 kitchen storage areas are well maintained with sufficient stock for residents for at least a week, and other stock that has been in the pantry for much longer and not always used according to the cook during interview. There is a potential for food safety/quality to be compromised due to inconsistencies around the recording of best before, use by or expiry dates on decanted dry food items. Twenty decanted food items were observed in the pantry that did not have any date on the container. The cook and kitchen hands have not completed, or updated, training in safe food handling practices. There is also no evidence that stock rotation occurs. Dates are not being noted on food coming into the facility. The approved food safety plan for the facility was not available on the day of the audit.	Food storage is not occurring according to recommended guidelines and there is no evidence that stock rotation occurs. Kitchen staff have not completed the recommended training. A food safety plan was not available.	Food safety processes are maintained and food preparation and storage comply with current legislation and guidelines. Relevant training is completed. 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are	PA Moderate	Information is documented on a range of assessment tools to inform and update the care plan. While progress has been made and there is a plan for six monthly interRAI assessments to be completed, there	InterRAI assessments are mostly being completed six-monthly with 12 overdue since May 2017. However, the interRAI is not being used as the primary assessment tool, and a range of assessment	The interRAI is used as the primary assessment tool as indicated in D15 A of the contract with the DHB, with other assessments to be undertaken as clinically indicated. Ensure that six

documented to serve as the basis for service delivery planning.		are still twelve overdue; seven were due in May; three due in June and two in July. Of the seven in May, five have been completed and are awaiting sign off from the external assessor, who was on leave at the time of the audit. The interRAI is not being used as the primary assessment tool and a variety of assessment forms for the same problem are being used, when, for example, nutritional assessment occurs. This has the potential to compromise the integrity of the care plan, for example, different nutritional supplements were recorded.	forms are being completed, but not all have the same finding. This potentially compromises the integrity of the care plan.	monthly interRAI assessments are completed on time. 90 days
Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is	PA Low	The new management were unable to access any regular reporting from the first five months of the year to enable a robust review of data as required by the Standard. However, regular reporting is now in place on a monthly basis which will enable 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, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. Internal audits are also planned to inform this meeting and all future six monthly organisational evaluations.	A comprehensive review process is planned to review the organisation's ongoing restraint practice. This will examine trends, outcomes, compliance with policies and procedures, use of alternatives, any changes to policy required and whether any additional training needs are identified. This has yet to be implemented.	Implement the organisational review process to review all restraint processes and make any changes indicated following the review. 180 days

necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.		The clinical nurse leader confirmed in interview that the first review meeting is planned for November of this year when sufficient data will have been collected.		

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.