

# Heritage Lifecare limited - Cantabria Lifecare

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## 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:** Cantabria Lifecare

**Services audited:** Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care

**Dates of audit:** Start date: 23 November 2017     End date: 24 November 2017

**Proposed changes to current services (if any):** Proposed purchase of facility and eight rest home beds suitable for dual purpose beds.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 176



# **Executive summary of the audit**

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## **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.

## **General overview of the audit**

Cantabria Lifecare provides rest home and hospital level care for up to 236 residents. The service is operated by Cantabria Home and Hospital Ltd and managed by a nurse manager. Residents and families spoke positively about the care provided. Eight rest home beds were suitable to become dual purpose beds.

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 review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, and a general practitioner. A representative for the proposed purchaser was onsite during the audit.

This audit has resulted in no areas identified for improvements.

## **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. Residents and families understood the complaints process and felt able to make a complaint if they needed to.

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 is no evidence of abuse, neglect or discrimination.

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

## **Organisational management**

The purpose, values, philosophy, direction and goals of the service are identified in the quality and business plans which are reviewed every two years. Operational plans have also been developed that enable the actioning and monitoring of annual and long-term goals. During absences of the manager, delegated authority is given to other senior managers/clinical leads to carry out the required duties that ensures uninterrupted services are provided to residents.

The principles of continuous quality improvement are reflected in Cantabria's quality and risk management system. Evidence includes the response to and evaluation of complaints, the instigation of regular resident satisfaction surveys, management of

incidents and accidents, management and monitoring of infections, falls prevention, monitoring of wounds including pressure injuries, and a comprehensive staff education attendance monitoring system.

Cantabria Lifecare has a comprehensive set of human resources management policies and processes that are based on current employment practices and relevant legislation. The human resources manager has developed a number of online tools, databases and prompts through the time target system used by staff when logging in for shifts. This ensures that all staff receive orientation and ongoing training specific to their roles within the service.

The human resources manager coordinates a process for ensuring that staffing levels and skill mixes are appropriate for providing safe services to residents, 24 hours a day, seven days a week.

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

Heritage Lifecare Limited are in negotiation with Cantabria Home and Hospital to purchase the facility and it is anticipated that the change of ownership will occur in January 2018 with a transition plan from the current to the new owners being developed.

## **Continuum of service delivery**

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

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## **Safe and appropriate environment**

The internal and external environment of the facility meets the needs of residents. The facility has a current building warrant of fitness. Electrical and medical equipment is tested as required. Communal and individual spaces are accessible and enable residents to mobilize safely. External areas are well maintained and are safe.

Health and safety considerations relating to waste, hazardous substances, chemicals and soiled laundry are managed well. Staff use protective equipment and clothing where required and all chemicals, soiled linen and equipment are appropriately stored. Laundry is carried out on site and products and procedures are evaluated for effectiveness.

Emergency procedures, and the use of emergency equipment and supplies are known well by staff. Residents and staff participate in regular fire evacuation practises. Call bells are responded to in a timely manner and residents reported feeling safe.

## **Restraint minimisation and safe practice**

The organisation has implemented policies and procedures that support the minimisation of restraint. Five enablers and seven restraints are 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.

## 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	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

# Attainment against the Health and Disability Services Standards

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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	Cantabria Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy to meet the needs of all residents including young people with disabilities and residents with a cognitive impairment. 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. The manager provided examples of the involvement of Advocacy Services in relation to staff education.
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 and young people with disabilities 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	Information on the Code and the services complaints procedure is provided to residents and their families on admission to the service. The service has a complaints policy and associated forms that comply with Right 10 of the Code and residents said that they were aware of the complaints process and knew how to make a complaint if they needed to. The staff and residents interviewed indicated that residents and their families would often discuss any concerns they had with staff before needing to make a complaint and that these matters would be dealt with quickly.  All complaints are filed in the complaints register that is maintained by the nurse manager and management support manager. Twenty two complaints or concerns had been raised during the previous 12 months and recorded in the complaints register. A review of the register showed

		<p>that all complaints/concerns had been acted upon in a timely manner with actions taken and resolutions achieved noted. Follow up and linkages to the quality improvement system were also recorded. All staff interviewed had a thorough understanding of the complaints process and how to assist people and families to lodge a complaint if required. No external complaints had been made since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, and in discussion with staff. The Code is displayed in communal areas together with information on advocacy services, how to make a complaint and feedback forms. The prospective provider knows and understands consumer rights that it must adhere to.</p>
<p>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.</p>	FA	<p>Residents, young people with disabilities and their 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.</p> <p>Young people with disabilities are encouraged to maintain their independence by community activities, arranging their own visits to the doctor, participation in clubs of their choosing and going out with family on a daily basis. 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>

<p><b>Standard 1.1.4: Recognition Of Māori Values And Beliefs</b></p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of 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. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</p>
<p><b>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</b></p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example, music preferences. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p><b>Standard 1.1.7: Discrimination</b></p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. 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.</p>
<p><b>Standard 1.1.8: Good Practice</b></p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education</p>

		and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	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 all residents able to speak English and staff being able to provide interpretation as and when needed. Language and communication needs and use of alternative information and communication methods are available and used to support young people with disabilities.</p>
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Cantabria Lifecare has a strategic and a business plan which have been approved by the owners and governance of the proposed purchaser. The purpose, values, philosophy, direction and goals of the service are identified in these plans which are reviewed every two years. Operational plans have also been developed that enable the actioning and monitoring of annual and long term goals. The board of directors (including the owner) receive monthly reports on the operations of Cantabria Lifecare including complaints, occupancy, incidents and accidents, quality data, staffing, financial performance and risk analysis.</p> <p>A nurse manager is employed to manage the service and holds a current annual practising certificate, in addition to other relevant qualifications required for managing the service. This person has held the role for two and a half years and has worked in the aged care sector for 26 years, 14 years as a manager. The nurse manager worked as a facility manager in another Cantabria Group facility for seven years before managing Cantabria. The nurse manager is assisted by a</p>

		<p>management support person who also holds relevant management and clinical qualifications but does not hold a current nursing registration. The roles, responsibilities and accountabilities of both managers are clearly defined in their respective individual employment agreements and position descriptions. The nurse manager confirmed during interview that they had a good knowledge of the aged and disability care sector including the reporting and regulatory requirements and regularly attends professional development opportunities including quality seminars, age care education and training sessions and clinical in-service education and training. The management team is assisted by clinical team leaders and non-clinical supervisors within the various sections of the service.</p> <p>Heritage Lifecare Limited is in negotiation with Cantabria Home and Hospital to purchase the facility. It is anticipated that settlement could occur by the end of January 2018. Heritage Lifecare is working with the owners and managers of Cantabria Home and Hospital to ensure a seamless transition during the change of ownership to ensure residents receive continuity of care during this time. The Heritage Lifecare Senior Manager; Quality and Compliance stated that a transition plan has been developed and includes the tasks to be carried out, responsibilities and timeframes. Heritage Lifecare operate a number of rest home facilities throughout New Zealand and have a very good understanding of all contractual and legislative requirements associated with the provision of services currently provided at Cantabria Home and Hospital including ARRC, Long Term Chronic and Young Persons with Disabilities agreements.</p> <p>At the time of audit:</p> <ul style="list-style-type: none"> <li>- 155 residents were receiving services under the Age Related Residential Care contract (94 hospital and 50 rest home level, 11 dementia care),</li> <li>- 10 residents None Aged contract with MOH (seven hospital and three rest home level),</li> <li>- four Long Term Chronic contract (one hospital and three rest home level),</li> <li>- four Respite Care (two rest home and two hospital level)</li> </ul>
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		<p>Eight rest home beds in the Golf wing were reviewed and approved as suitable to become dual purpose (hospital or rest home) beds.</p> <p>Heritage Lifecare have a very good understanding of their obligations under the ARRC and other agreements currently held by Cantabria and will be able to appropriately support residents under this agreement.</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.	FA	Whenever the nurse manager is absent, the management support manager and four senior clinical leads have delegated authority to carry out the required duties that ensures uninterrupted services are provided to residents. Two nurse managers from sister sites within the Cantabria Group are also available as required. Training opportunities are provided to senior and clinical staff to enable them to assume leadership roles when senior managers may be absent. Staff reported that current arrangements work well, and that the owner is always available by phone or email if required. The Heritage Lifecare Senior Manager; Quality and Compliance stated that the organisation has service management systems that will enable it to manage staff, changes in staff and rosters when it assumes management of the service. These details are included in the transition plan developed by Heritage Lifecare.
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	<p>The principles of continuous quality improvement are reflected in Cantabria's quality and risk management system. Evidence includes the response to and evaluation of complaints, the instigation of regular resident satisfaction surveys, management of incidents and accidents, management and monitoring of infections, falls prevention, monitoring of wounds including pressure injuries, and a comprehensive staff education attendance monitoring system.</p> <p>Quality data is used by managers throughout all aspects of the service to improve the quality of service being provided to the residents. Minutes of management, quality, health and safety teams and staff meetings showed that data is reviewed on a regular basis, analysed and actions taken to improve service delivery. Staff interviewed reported that they had been involved in project groups including falls</p>

	<p>prevention and pressure injury mitigation. Corrective actions are developed, implemented and reviewed to address any gaps in service provision. Examples included the rehousing and updating of emergency and civil defence equipment to a location where it is accessible and appropriate for the needs of residents and staff, and responses to concerns or comments made by residents or their families. Any actions taken to improve the quality of service are clearly documented to show actions taken, timeframes are met and that outcomes are evaluated.</p> <p>All service and contractual requirements are covered by policies that have been developed and are regularly reviewed, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are developed and reviewed based on best practice and were current. A document control system is applied to all policy and procedure documentation including forms. This system is currently being reviewed with a view to improving its effectiveness. The service maintains a paper based approach to all policies, although they can be referenced electronically as well.</p> <p>The process for the identification, reporting, reviewing and monitoring of risks was described by the nurse manager, management support manager and the health and safety officer (RN). All members of the senior management team interviewed were familiar with the Health and Safety at Work Act (2015) and have ensured the implementation of requirements under the Act.</p> <p>Satisfaction surveys are sent to residents and families annually. Summary information from the most recent survey highlighted that actions had been taken on areas of concern. Residents interviewed confirmed that any concerns they have are dealt with quickly and efficiently.</p> <p>The Heritage Lifecare Senior Manager; Quality and Compliance stated that the organisation has a comprehensive suite of policies and procedures that will enable it to meet the requirements of the health and disability services standards when assuming responsibility for the management and operation of Cantabria. Heritage Lifecare also have a quality management system that they would introduce in a staged manner to allow sufficient lead in time. The organisation has a quality plan that is reviewed regularly and guides the organisations continuous quality improvement initiatives including the scheduling of internal</p>
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		audits, satisfaction surveys and continuity planning.
Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	<p>Staff interviewed had a good understanding of what an adverse event is and where to record them. Any adverse event or near miss event is recorded on an accident/incident form. Review of a sample of incidents forms revealed that these were completed in full, investigations completed with corrective actions written where required and timeframes for actions given. Senior managers, the quality group and the board (including the owner) receive regular reports on adverse events with any increases or trends noted.</p> <p>The nurse manager was very knowledgeable about the reporting requirements surrounding adverse events, including for pressure injuries. One notification of an event has been to the Ministry of Health, since the previous audit (one pressure injury). An infection outbreak was notified to public health in November 2017. There have been no police investigations, coroner's inquests or issues based audits.</p> <p>At interview, The Heritage Lifecare Senior Manager; Quality and Compliance stated that the organisation has policies and procedures for the recording and reporting of adverse events and the organisation understands its statutory and/or regulatory obligations in relation to essential notification reporting. The appropriate authorities would be notified where required.</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.	FA	Cantabria Lifecare has a comprehensive set of human resources management policies and processes that are based on current employment practices and relevant legislation. The human resources manager has developed a number of online tools, databases and prompts through the time target system used by staff when logging in for shifts, to ensure that all staff receive orientation and ongoing training specific to their roles within the service. Staff recruitment processes include referee checks, police vetting and validation of qualifications and annual practising certificates (APCs) where required. A random selection of staff files were selected for review and it was confirmed that the services human resources policies were being adhered to. Recent

		<p>quality improvements to the filing of staff records by the service has resulted in information being consistently located in the correct section of each file.</p> <p>All staff have a six week orientation that includes all necessary components relevant to the position they hold. Staff interviewed thought that their orientation was comprehensive and prepared them for their roles well. Staff felt that they were given sufficient time to become competent in their role before having to work alone. Staff files reviewed contained completed orientation documentation, and evidence that staff received a performance review six weeks after starting work. All staff annual performance appraisals had been completed.</p> <p>The training and development manager has developed and maintains an annual training calendar that includes mandatory training for staff at all levels throughout the service. Staff interviewed had a good knowledge of the calendar and found the colour coding of training opportunities, that were specific to particular roles, useful. There are sufficient numbers of trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Care assistants have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the Cantabria Lifecare's agreement with the local DHB. A senior member of staff acts as the internal assessor for the programme. Staff working in the dementia care wing have either completed or are enrolled in the required education. Staff are not able to work in the dementia wing if they do not have the minimum training required to do so.</p>
Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The human resources manager coordinates a process for ensuring that staffing levels and skill mixes are appropriate for providing safe services to residents, 24 hours a day, seven days a week. The service has the capacity to adjust staffing levels to meet the changing needs of residents as required. Human resources staff and the clinical leads, use InterRAI to ensure that they have the appropriate mix of staff to support residents at any time. An after-hours on call roster is in place, enabling shifts to be filled at short notice by regular staff before agency staff need to be called upon. Care assistants interviewed thought that there

		<p>was adequate staff available to complete the work allocated to them. Feedback from residents, families and satisfaction survey results supported this. Review of rosters for a six week period showed that adequate staff cover has been provided during this time and that staff had been replaced when there was an unplanned absence. All registered nursing staff and activities staff hold current first aid certificates and there is 24 hour/seven days a week RN coverage in the hospital.</p> <p>Heritage Lifecare have not identified any changes being required to key personnel that will occur after taking ownership of the service and will work with current staff to ensure that the residents health and safety is not compromised during the change-over.</p> <p>Heritage Lifecare have human resource policies and procedures that enable them to ensure that appropriately qualified and experienced staff are available at all times to meets the needs of residents. The Heritage Lifecare Senior Manager; Quality and Compliance stated that staffing policies are based on current and best practice standards that ensure safe aged care support is provided. Heritage Lifecare have a staff rostering tool the enables them to roster staff according to the needs of residents in any service they operate. a very good understanding of their obligations under the ARRC agreement currently held by Cantabria and will be able to appropriately support residents under this agreement.</p>
Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	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</p>

		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	<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. There is consideration given to young people with disabilities on entering the service during the admission process, including assessment confirming the appropriate level of care. The organisation seeks updated information for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments. Signed admission agreements evidenced Enduring Power of Attorney (EPOA) documentation supporting admission 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	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's admission to Lakes District Health Board template which is supported by a facility transfer letter and associated documents to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whanau. 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 hospital showed communication with the hospital, NASC team and family/whanau. Family of the resident reported being kept well informed during the transfer of their relative.</p>

<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management 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.</p> <p>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 and on request.</p> <p>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.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are used, were current and complied with guidelines.</p> <p>There were two residents self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met</p>	<p>FA</p>	<p>The food service is provided on site by qualified cook and a kitchen team and overseen by a kitchen supervisor and is in line with recognised nutritional guidelines for older people. The menu follows</p>

<p>where this service is a component of service delivery.</p>		<p>summer and winter patterns and is due to be reviewed again alongside the current development of an approved food safety plan. The nurse manager stated that they are aware of the current deadline in March of 2018.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen supervisor and cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit and young people with disabilities have access to food and fluids to meet their nutritional needs and preferences at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meetings 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>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC 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.</p>

Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as, pressure injury risk, pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of 24 trained interRAI assessors on site. 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	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. Residents files reviewed for behaviour management plans included triggers and interventions for behaviour specific and individual to the resident.  Care plans for young persons with a disability are person centred, developed with the person and their family if appropriate, and includes their well-being, community participation, meeting physical and health needs.  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.
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 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. One GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a very high standard.

		Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
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	<p>The activities programme is provided by five activity assistants. There is currently no diversional therapist based at the facility, however the activity assistants have support and guidance from two local diversional therapists in the community who hold the National Certificate in Diversional Therapy.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three 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 and satisfaction surveys. Residents interviewed confirmed they find the programme interesting and interactive and are encouraged to participate.</p> <p>Young people with disabilities are encouraged and supported to participate in a range of education, recreation, leisure, cultural and community events consistent with their individual interests and preferences. Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless, such as music and one to one interaction.</p>
Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a	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.

<p>comprehensive and timely manner.</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 and wounds. When necessary, and for unresolved problems, long term care plans are added to an 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)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has regular GPs who visit, 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 the dietitian, gerontology services and mental health services for the older adult. The resident and the family/whānau are kept informed of the referral process, as was 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</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The service has clearly documented procedures for the handling and management of waste as well as infectious and hazardous substances. Signage is displayed in areas where there are hazardous substances and are appropriate for the service. Training is provided for staff who deal with hazardous substances, including chemicals, and staff interviewed felt that they received appropriate support to work with hazardous substances and chemicals. The service contracts an external supplier for chemicals and cleaning products, providing staff with fact sheets on each product and specific training where required. Equipment for emergency spills is provided throughout the facility and staff interviewed knew what to do should any chemical spill/event occur.</p>

		Personal protective equipment is available for staff, particular cleaning and laundry staff, who commented during interview that they had good access to all the protective clothing and equipment they needed.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The service has a current building warrant of fitness that expires on 12 October 2018 and is displayed in the main reception area.</p> <p>The purchasing manager who has responsibility for the facilities has systems in place that ensure the physical environment and facilities are fit for purpose and maintained to a standard that promotes the welfare and safety of residents. Electrical equipment is tested and tagged where necessary and all residents' rooms have been fitted with residual current devices (RCD) devices to ensure all electrical equipment is safe to use. Medical equipment testing is current as confirmed in documentation reviewed, interviews with maintenance staff and observation of the environment. Environmental hazards are reported and responded to quickly. There are maintenance books throughout the facility which staff record any issues that they are aware of. These books are checked two to three times a day and action is taken quickly.</p> <p>The dementia wing is located on a lower ground floor of the facility and has a dedicated outdoor area that is easily accessible for residents. Although the perimeter of the outdoor is secured by fencing, emergency egress is provided when necessary that allows residents to be assisted away from the building in a safe and appropriate manner. Residents with disabilities have access to any specialised equipment they may require, and the layout of the facilities enables residents to freely mobilise throughout the complex including access to outdoor spaces. The Heritage Lifecare Senior Manager; Quality and Compliance confirmed that the company does not have any plans to change the physical environment.</p> <p>External areas are well maintained and are appropriate to the residents' needs. The dementia wing has its own secure outdoor area.</p>
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	The facility has an adequate number of accessible bathroom and toilet facilities that meet the needs of the residents. The majority of rooms

<p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>have ensuites, while a small number of rooms share an ensuite. Bathroom and toilet areas vary in size with many able to accommodate specialised equipment including hoists and shower chairs. All bathroom and toilet areas have handrails fitted appropriate to the needs of residents. Work is currently being completed on updating ensuites with appropriate floor and wall coverings throughout the facility.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents' have adequate personal space in their bedrooms that allows them and the staff assisting them to manoeuvre safely. Where resident's use mobility equipment, including wheelchairs or mobility scooters, these people tend to have larger rooms that is able to accommodate their equipment. During audit, one bedroom was shared by a husband and wife by choice and all other rooms were single occupancy. Approval for the shared room had been sought. All rooms were personalised with furnishings, photos and other personal items displayed.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The facility has a variety of indoor and outdoor communal areas for residents to engage in activities of their choice. Each wing has an open plan dining and lounge area that is easy to access and meets the needs of residents and staff. Each wing also has a small kitchenette where hot drinks and snack foods can be accessed. Dining and lounge furniture in all wings is appropriate for the residents with specialised seating provided where needed.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></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>	FA	<p>A team of cleaning staff take responsibility for ensuring that the facility is maintained to a high standard. Cleaners' trolleys were equipped with appropriate cleaning products and equipment. Cleaning staff interviewed felt that they had good access to cleaning products and personal protective equipment. These staff receive regular training on product and chemical use as well as the core training that all staff must attend, as confirmed during interview and review of training records.</p> <p>Residents' and facility laundry is carried out at the facility in dedicated</p>

		<p>laundry areas that are appropriately equipped. The service employs dedicated laundry staff who have a good understanding of how to process laundry according to best practice standards including dirty to clean flow and dealing with soiled linen/garments. Residents interviewed were happy with the laundry service provided and thought that it had improved over the last 12 months.</p> <p>The service has a good relationship with the suppliers of chemicals and cleaning products who regularly monitor and test their products for effectiveness. Any changes are made known to staff. The service also conducts internal audits which include the monitoring of the cleaning and laundry processes.</p>
Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations.	FA	<p>The service has appropriate policies and procedures for emergency planning, preparation and response. Emergency protocols are displayed throughout the facility and are known by staff who receive training on emergency response as part of their orientation and ongoing core training. As in the previous audit, the current fire evacuation plan was approved by the New Zealand Fire Service on the 11 October 1995. The service is seeking an updated approval of the evacuation scheme from the New Zealand Fire Service. Trial evacuations take place every six months with copies sent to the New Zealand Fire Service. Specific training is provided to all nominated floor wardens.</p> <p>A small building on the property has been dedicated to housing emergency supplies for any civil defence emergency events. The health and safety coordinator checks these supplies monthly and perishable items are replaced as necessary. Emergency supplies include food, water, blankets, mobile phones, torches, batteries and gas BBQ's and sufficient supplies are available to support all residents and staff when the facility is at full occupancy. The services has two generators on site and water storage tanks with filtration units are located around the facility. Emergency lighting is test regularly. Records reviewed show that emergency plans are reviewed annually to ensure that they meet the requirements of all stakeholders. The needs of residents with dementia and disabilities are specifically referenced in the emergency plans and measures have been put in place to ensure that they are able to safely exit the building if required or staff and emergency services will</p>

		<p>assist them if they are unable to ensure their own safety. The facility has a defibrillator and all registered nurses have been trained in the correct use of this.</p> <p>Residents have access to a call bell system enabling them to summon staff assistance when required. Residents interviewed indicated that response times to call bells has improved since last year. It was observed that call bells were answered promptly during the days of audit.</p> <p>The facility has appropriate security arrangements in place to ensure the safety of residents and staff. External doors and windows are locked at a predetermined time and a security company checks that external doors are secure during the night, seven days a week. CCTV cameras are located in all common areas and these are monitored by the nurse manager and administrator.</p>
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 rooms and communal areas throughout the facility are heated and ventilated appropriately. Residents' rooms all have natural light, external opening windows and many rooms, excluding the secure dementia care wing, have doors that open on to outside garden areas. The majority of heating throughout the facility is provided by thermal bore water heated radiators in residents' rooms which can be individually thermostat controlled. Larger communal areas, like dining rooms, lounges and activities rooms, have heat pumps and radiators. The facility was warm and well ventilated throughout the audit. Residents interviewed thought that the facility was maintained at a comfortable temperature all year round.
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 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 consultant. The infection control programme and manual are reviewed annually.  The clinical coordinator/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job

		<p>description. Infection control matters, including surveillance results, are reported monthly to the nurse manager and owners, and tabled at the quality/risk committee meeting. This committee includes the nurse manager/IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for two years. She has attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>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</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in April 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><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</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 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 an outbreak occurred in September 2017.</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><b>Standard 3.5: Surveillance</b></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 are 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 the nurse manager/quality, IPC committee and owners.</p> <p>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 have now been incorporated into practice, with additional staff education implemented.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></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</p>

		<p>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/his role and responsibilities.</p> <p>On the day of audit, seven residents were using restraints, all were hospital level residents. Five 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.</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>The prospective provider during interviewed confirmed their commitment in meeting the requirements of the restraint minimisation standards.</p>
Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	<p>The restraint approval group, made up of the nurse manager, a person in the role known as 'management support', and RN, 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, residents' files and 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 analysed.</p> <p>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.</p>
Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	<p>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 RN/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</p>

		<p>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.</p>
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The use of restraints is actively minimised. The restraint coordinator described how alternatives to restraints are discussed with staff and family members (e.g., the use of sensor mats and low beds).</p> <p>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.</p> <p>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.</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 and how to maintain safety when in use.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>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 was completed as required</p>

<p><b>Standard 2.2.5: Restraint Monitoring and Quality Review</b></p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this included analysis and evaluation of the numbers 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. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with staff confirmed that the use of restraint has been reduced by half over the past year.</p>
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## **Specific results for criterion where corrective actions are required**

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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.

No data to display
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## **Specific results for criterion where a continuous improvement has been recorded**

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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.