

St Patricks Limited - St Patricks Home and Hospital

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	St Patricks Limited
Premises audited:	St Patricks Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 January 2018 End date: 10 January 2018
Proposed changes to current services (if any):	St Patricks Home and Hospital requires a provisional audit due to the pending sale of the facility to a new owner.
Total beds occupied across all premises included in the audit on the first day of the audit:	53



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

General overview of the audit

St Patrick's Home and Hospital can provide care for up to 60 residents. There were 53 residents at the facility on the first day of audit. This provisional audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer. The provisional audit was undertaken to establish how well prepared the prospective provider is to provide a health and disability service.

The facility manager is responsible for the overall management of the facility including clinical care and is supported by the acting clinical manager and two directors. Service delivery is monitored. Previous improvements from the surveillance audit have been closed.

There are improvements required following this provisional audit in informed consent, care planning and restraint.

Consumer rights

Staff are informed of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service.

Information packs are provided to new residents and family members on entry to the service. Residents and family members confirmed they are involved with review of the individual care plans. Family are updated if any changes occur in the resident's condition in a timely manner. Residents and family meetings are held monthly. Interpreter services are accessed when required and a multicultural staff mix enables interpretation to occur by staff where appropriate.

Communication occurs for staff using a communication book, staff meetings and emails. Open communication between staff, residents and families is promoted and was observed and confirmed on interview.

A complaints register is maintained and up to date. Complaints are investigated within the required timeframes and documentation is maintained. Residents and family members confirmed on interview, that their rights are met. Staff were observed as being respectful of their resident's needs.

Organisational management

St Patricks Home and Hospital has a documented quality and risk management system. There is a system to manage residents' records with a document control process in place.

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

Continuum of service delivery

Registered nurses provide information packs on what the facility offers to potential residents and their families.

Staff are suitably qualified and skilled to meet the needs of the residents. Required timeframes around initial care plans and long-term care plans are adhered to. Long-term care plans show changes to the plan when the condition of the resident changes. Short-term care plans are used for the management of wounds.

The general practitioner completes medical reviews of all residents on admission and at least three monthly or when the health needs of residents change. Referrals to other health and disability services are planned and coordinated, based on the individual needs of residents.

The activities programme meets the social and recreational needs of the residents, including the needs of those that are under 65 years of age. Activities are planned, and residents and their families confirmed activities are meaningful to residents. There is evidence that residents maintain links with the community and family.

The medication system was observed during the audit. Registered nurses and senior caregivers are responsible for medication management. Staff who administer medicines complete annual competencies to ensure safe systems and processes. Education and training records confirmed relevant ongoing medicines management training for staff to safely perform this role.

Residents' nutritional needs are assessed, including special diets and resident food preferences. The food service provides alternative options at mealtimes. The cook and kitchen staff have completed food safety training. An independent dietitian reviews menus and recipes biannually.

Safe and appropriate environment

There is a current building warrant of fitness and New Zealand Fire Service evacuation scheme in place. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings, and floor and wall surfaces are made of accepted materials for the environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help, when needed, in a timely manner.

The provisional audit confirmed that the prospective provider is not currently planning to make any environmental changes to the service.

Restraint minimisation and safe practice

Restraint management is documented in policies and procedures. Enabler use is voluntary and the least restrictive option is used. There were three residents using enablers and three using restraint at the time of audit. Restraints and enablers were in the form of lap belts and bedrails. The restraint coordinator is a registered nurse.

Restraint forms include consent, review and monitoring of restraint, as well as a register recording all enablers and restraints.

Infection prevention and control

The responsibility for infection control is clearly defined and the assistant clinical manager is the infection control coordinator. There are clear lines of accountability for infection control. The service has a clearly defined infection control programme, with a suite of up-to-date policies to guide service provision. The infection control programme was last reviewed at the end of 2017. Infection control meetings form part of staff meetings. Hand sanitizer was observed being used throughout the facility, including at reception.

The infection prevention and control management system is appropriate for the size and complexity of this service. Staff receive orientation and ongoing training on infection prevention and control. Residents and their families are provided with relevant education when needed.

The infection control coordinator collates monthly infection surveillance data and reports this to the manager. Reports show comparative data. Trends are identified and corrective actions are implemented when required. Infection surveillance results are reported to the owner and feedback given to staff at meetings. Benchmarking occurs against other similar services.

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	47	0	0	3	0	0
Criteria	0	96	0	0	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Staff receive education on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the education programme with this provided in 2017. Staff could explain rights for residents in a way that promotes choice. Posters identifying residents' rights are displayed in the facility.</p> <p>Residents and families stated that they receive services that meet their cultural needs and they receive information relative to their needs. Residents and families confirmed that staff respect their wishes.</p> <p>Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practise their own personal values and beliefs.</p> <p>The auditors noted respectful attitudes towards residents on the days of the audit.</p>

<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	<p>PA Moderate</p>	<p>There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent. The informed consent policy and procedure includes guidelines for consent for resuscitation/advance directives, however a review of files demonstrated that the doctor signs the advance directive. The policy and procedure needs to be updated to include guidelines for consent for resuscitation/advance directives and the surveillance cameras in the communal and external areas of the facility. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.</p> <p>All resident files identified that informed consent is signed for the following: routine cares and procedures; information to be collected; sharing of information with family; the listed routine procedures to be carried out; visiting personnel/students and use of a photograph. Interviews with staff confirmed their understanding of informed consent processes.</p> <p>The service information pack includes information regarding informed consent. A RN or the ACM discusses informed consent processes with residents and their families during the admission process.</p> <p>All residents sign an admission agreement on entry to the service.</p> <p>The informed consent policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files demonstrated that the doctor signs the advance directive and an improvement is required.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Staff stated that written information on the role of advocacy services is provided to residents at the time of entry to the service. Information concerning advocacy services is included in the information pack given to new residents and/or family. There is also information available at the entrance to the service on advocacy services.</p> <p>Staff training on the role of advocacy services is included in training on The Code. This was last provided for staff in 2016.</p>

		<p>The Health and Disability Commission advocate visits the service during the year as confirmed by the management team and through meeting minutes.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions. Family and residents stated that they have been informed about advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked.</p> <p>Families interviewed confirmed they could visit at any time and are always made to feel welcome.</p> <p>Residents are encouraged to be involved in community activities and to maintain family and friend networks. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments, with a van able to take residents into the community.</p> <p>Residents, including a young person with a disability, confirmed active involvement with family and friends in the community.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and evidence of resolution of issues.</p> <p>The complaints register includes documentation of verbal complaints. Evidence relating to each lodged complaint is held in the complaint's folder. Complaints lodged in 2017 were reviewed and indicated that most of the complaints are investigated with the issues being resolved.</p> <p>The manager is responsible for complaints management and residents</p>

		<p>and family state that these are dealt with as soon as they are identified.</p> <p>There are two complaints lodged with the Health and Disability Commission and one with the Auckland District Health Board that remain open.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The assistant clinical manager (ACM) or a registered nurse (RN) discusses the Code, including the complaints process, with residents and their family on admission. Discussions relating to the Code can also be held at the resident meetings. Residents and family interviews confirm their rights are being upheld by the service. The information pack includes reference to the Code, displayed in the facility.</p> <p>Information is given to next of kin, enduring power of attorney (EPOA) or family to read to and discuss with the resident in private. Residents and family members were able to describe their rights and access to advocacy services.</p> <p>For the provisional audit the prospective provider confirmed their understanding of consumer rights. This was confirmed during interview with the prospective directors.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. The initial and ongoing assessments gain details of people's beliefs and values, with care plans completed with the resident and family member. Interventions to support these are identified and evaluated. Resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified.</p> <p>The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings.</p> <p>Healthcare assistants reported that they knock on bedroom doors prior</p>

		<p>to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families confirmed that residents' privacy is respected.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training on abuse and neglect and could describe signs. There were no documented incidents of abuse or neglect in the service reports for 2017 or on the incidents reviewed in residents' files. Residents, staff, family and the general practitioner (GP) confirmed that there is no evidence of abuse or neglect. Staff interviewed were aware of the need for them to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</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>The organisation has a cultural policy which outlines the processes for working with people from other cultures. The rights of the residents/family to practise their own beliefs are acknowledged in the policies documented.</p> <p>The facility has Maori staff who support the care needs of Maori residents as necessary. At the time of the audit, there were no residents who identified as Maori. Staff reported that specific cultural needs are identified in the residents' care plans. One of the new directors is a leader of a local iwi and stated his availability to support the service in Maori cultural competency requirements where required.</p> <p>Staff are aware of the importance of family/whānau in the delivery of care for Māori residents. Training records demonstrated that staff have received training around cultural rights, safety and Māori in 2016.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Interviews with residents and families confirmed that the service identifies each resident's personal needs from the time of admission. This is achieved with the resident, family and/or their representative. There is a culture of choice with the resident determining when cares occur, times for meals and options with meals and activities. Staff work</p>

		<p>to balance service delivery, duty of care and resident choice.</p> <p>Residents and family confirmed they are involved in the assessment and the care planning processes. Information gathered during assessment includes the resident's cultural values and beliefs. This information is used to develop a care plan.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family stated that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination.</p> <p>The facility implements policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, coercion, harassment and exploitation. Staff interviewed stated that they are aware of the policies and are active in identifying any issues that relate to the policy.</p> <p>The orientation and employee agreement provided to staff on induction includes standards of conduct, with clear expectations of boundaries outlined in job descriptions. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the healthcare assistants' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>St Patrick's Home and Hospital implements policies to guide practice. A quality framework supports a quality programme that includes all aspects of service delivery. There was evidence of monitoring of the service with improvements noted.</p> <p>There is a training programme for all staff and registered nurses are encouraged to complete training provided by the district health board and external agencies.</p> <p>Residents and families interviewed expressed a high level of satisfaction with the care delivered. The completed annual satisfaction surveys from 2017 also evidenced satisfaction with services. The GP interviewed expressed satisfaction with the clinical oversight and care provided.</p>

		<p>Consultation is available through the organisation's management team that includes the ACM, manager and managing directors.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The complaints procedure, accident/incidents, and the open disclosure procedure guide staff to their responsibility to notify family/EPOA of any accident/incident that occurs. These procedures also guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident or has a change in health status or a change in needs, as evidenced in completed accident/incident forms.</p> <p>Family contact is recorded in residents' files. Interviews with family members confirmed they are kept informed. Family also confirmed that they are invited to attend the resident meetings. There is a separate residents meeting for the Chinese residents who do not speak English, which is facilitated by the staff who speak Chinese.</p> <p>Interpreting services are available through the district health board. Staff are familiar with how translating and interpreting services can be accessed. The multicultural diversity of the current staff, enables staff to currently interpret for all the residents who require assistance. The auditors observed staff speaking fluently with the residents and families in their preferred language.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>St Patricks Home and Hospital operates under the structure of two companies. There are values, goals and a philosophy documented in the strategic overview of the service. The strategic plan also includes a marketing plan and a strengths, weaknesses, opportunities and threats analysis. These are communicated to residents, staff and family through information in booklets, in staff orientation and on the website.</p> <p>Two directors provide oversight of the service. The facility manager is a registered nurse with a current practising certificate and a Masters in Nursing. The facility manager and acting clinical manager have been recently appointed to their roles.</p> <p>The facility can provide care for up to 60 residents with 8 designated</p>

		<p>bedrooms for rest home level of care. Other bedrooms are designated as dual purpose beds (hospital and rest home). During the audit there were 53 residents living at the facility, including 21 residents requiring rest home level of care and 32 residents requiring hospital level care. Of these numbers, there are 6 rest home level residents and 7 hospital level residents in the 13 beds located in the outside units. One resident was identified as a young person with a disability (YPD) on a chronic care long-term contract. There is a designated healthcare assistant and RN assigned to care for the residents in the outside units for each shift.</p> <p>The prospective owners are the husband of the current facility manager, the facility manager and the current acting manager: "At the provisional audit the auditor established that the prospective providers stated their transition plan is to keep all operational processes the same with only the directors changing and intend to continue with the same quality processes as set out in the previous provider's quality and strategic plans There are no planned changes to staffing other than the acting clinical manager (ACM) will formally become the clinical manager (CM).</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the facility manager, the ACM is appointed as second in charge with support from the directors. The current ACM appointed to the role is newly appointed as second in charge and the facility manager is in the process of formalising the role with the ACM. The ACM has been working in the service for seven months.</p> <p>The facility manager will continue to have an overview of clinical services supporting the ACM as she transitions into the formal clinical manager role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>St Patricks Home and Hospital uses a quality and risk management framework that is documented to guide practice.</p> <p>A comprehensive quality plan is documented and this includes objectives and indicators with progress documented through monthly reports. The plan focuses on all aspects of the quality programme.</p> <p>The service implements organisational policies and procedures to</p>

		<p>support service delivery. All policies are expected to be reviewed two yearly and all have been reviewed in a timely manner. Policies are readily available to staff in hardcopy.</p> <p>Service delivery is monitored through complaints; internal audits, review of incidents and accidents; surveillance of infections; pressure injuries; wounds; two monthly reports around health and safety and monthly reports around service delivery. Corrective action plans are documented and evidence resolution of issues is completed.</p> <p>Progress against indicators are discussed at meetings including the monthly staff forum; health and safety; service continuum; resident forums; restraint meetings and management meetings. Family are able to attend the resident meetings if they wish. Staff reported that they are kept informed of quality improvements and were able to talk about improvements made to the service.</p> <p>The last satisfaction survey for family and residents shows a high level of satisfaction and this was confirmed by residents and family interviewed.</p> <p>The organisation has a risk management programme in place. An organisational risk management plan is documented and reviewed annually. An interview with the health and safety representative confirmed there are health and safety policies and procedures in place to guide practice and are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed and risks minimised or isolated.</p> <p>The provisional audit confirmed that the quality processes of the current provider will continue to be used by the prospective provider and that the only changes will be the change to the directors. Policies and procedures will stay the same.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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</p>	<p>FA</p>	<p>The facility manager is aware of situations in which the service would need to report and notify statutory authorities, including: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks and changes in key</p>

<p>manner.</p>		<p>managers. The Ministry of Health and district health board have been notified of any sentinel events, including, reporting of pressure injuries to the Ministry of Health.</p> <p>Staff receive education on the incident and accident process during orientation and as part of the ongoing training programme. Staff understand elements of the adverse event reporting process and could describe the importance of recording near misses.</p> <p>Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place. Interviews with the prospective provider confirmed their understanding and requirements for adverse reporting.</p> <p>Currently there are two Health and Disability Commissioners enquires and one District Health Board enquiry open. The service has provided all evidence requested by HDC and are awaiting the outcome/closure. Evidence was provided to confirm that the provider is working with the DHB and has an action plan in place in regard to the complaint that was under investigation.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The facility manager, ACM and all RNs hold current annual practising certificates along with other health practitioners involved with the service.</p> <p>Staff files include appointment documentation including signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal.</p> <p>All staff complete an orientation programme and healthcare assistants (HCA) are paired with a senior HCA for shifts or until they demonstrate competency on a number of tasks including personal cares. The HCAs confirmed their role in supporting and buddying new staff. A new staff member interviewed confirmed that they had completed an orientation programme, with evidence of staff training for physical and intellectual disability of younger residents.</p> <p>The organisation has an annual education and training programme.</p>

		<p>Staff attendances are documented for internal training with evidence that there is good attendance at training sessions. Registered nurses attend training provided by the district health board, including: wound management; pressure injuries; pain management; and nutrition in 2016/2017. Education and training hours are at least eight hours a year for each staff member.</p> <p>Three RNs have completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.</p> <p>At the time of the provisional audit, there were 45 staff, including clinical staff, staff who facilitate the activities programme and household staff. There is always a RN on each shift. The facility manager and ACM are on-call. If the facility manager is on leave, the ACM covers all on-call requirements. Residents and families interviewed confirmed staffing is adequate to meet the residents' needs.</p> <p>Staff will retain their positions and the prospective providers intend to continue with the education and training programme of the current providers. The three new directors will form the governance body with one of the directors staying in the role of manager and one as the clinical manager. The prospective providers will be taking over the current policies of the service and continue to use the policies for guiding service provision, this include the current skill mix policy.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and</p>

		<p>support information could be accessed in a timely manner.</p> <p>Entries are legible. Entries are dated and signed by the relevant HCA, RN or other staff member, including their designation.</p> <p>Resident files are protected from unauthorised access by being locked away in an office.</p> <p>Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder with medication.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The pre-admission and admission process of residents includes providing an admission pack to residents and their families as well as meeting and interviewing residents and family members to ensure appropriate placement of residents. The admission pack provides information and brochures on the facility and the services provided.</p> <p>The administrator, ACM and facility manager make themselves available as the contact people for enquiries. Residents reviewed during the audit were assessed for rest home or hospital levels of care, including NASC authorisation and assessment confirming the appropriate level of care for YPD. Admission agreements reviewed were all signed within the expected timeframes. Where enduring power of attorney oversight was indicated, resident files showed evidence of legal documentation to support such an appointment. The service maintains adequate continence and wound care products to meet the needs of the residents.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Transfers and discharge of residents include risk assessments to ensure the safety of residents and their family during this process. Registered nurse interviews confirmed risk assessment are completed and there is open disclosure between the service and family/whānau, including adverse event reporting.</p> <p>Residents and their families are encouraged to communicate with clinical staff. The ACM as well as the facility manager have an open</p>

		<p>door policy regarding their accessibility. Prior to residents being transferred to another service, the RN completes a full interRAI assessment to ensure continuity of care. Interviews with residents, their families and the GP confirmed they are informed during transfer processes.</p>
<p>Standard 1.3.12: Medicine Management</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>Medication management policies and procedure provide guidelines to ensure safe administration of medications.</p> <p>Medicines are provided by the pharmacy in a pre-packed delivery system. Medicine management was observed during the lunch time medication round. Medicines are stored in locked medicine trolleys which are stored in the treatment room. Medicines requiring refrigeration are stored separately in the medicines fridge. Drugs are stored securely in a locked safe in a locked room, with processes meeting medication legislation requirements. Staff complete regular drug register checks weekly and balances reviewed were correct.</p> <p>The facility uses an electronic system for medicines administration. Medication records are reviewed at three monthly intervals or when the health needs of the resident require review of their medicines. Medicines reviewed included the date, medicine name, dose and time of administration and maximum dosages as required. All medication records have photo identification and known allergies identified.</p> <p>Medicines management policies include guidelines for the management of Warfarin. Residents who are in respite care have an assessment completed and the medicines are managed using the same process that is used for all medicines. The general practitioner confirmed that residents who are receiving respite are usually seen by their own GP or when requested by the respite residents' GP, the facility's GP sees the resident.</p> <p>Staff responsible for medicines management complete annual competency testing. There are no residents self-administering medicines. The service has a self-medication policy in place to facilitate rest home and young people with disabilities wishing to self-medicate.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs a cook who is responsible for the management of the kitchen, including ordering of food, equipment and resources. Cleaning schedules are developed and implemented. Staff have current food safety competencies.</p> <p>There are four-weekly roll-over menus for summer and winter and a dietitian reviews the menus and recipes biannually. The last review by the dietitian occurred in 2017.</p> <p>A nutritional profile is completed for each resident by an RN when the resident is admitted to the service. A copy is provided to the kitchen. Food preferences are noted and special diets are considered and provided. The family/residents interviewed reported they are satisfied with the food and fluid services. Fridge and freezer temperature are monitored and recorded to meet food safety requirements.</p> <p>Food, fluid and nutritional needs of residents are in line with recognised nutritional guidelines. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines, as verified during the on-site audit.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</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>Registered nurse interviews confirmed that they require an assessment of the resident from the needs assessment and service coordination (NASC) services and/or an interRAI assessment to confirm the level of needs of the potential resident. Residents are declined admission to the service only when their health needs cannot be met by the level of service delivery at the facility or when there is no bed available at the time of the referral.</p> <p>When potential residents' needs cannot be met, the resident, their family and the referrer will be informed of the decision to decline, with information about other services that may be more suitable in meeting the individual's needs. Interviews confirmed that there has been no recent need to decline services to potential residents. Interviews confirmed that should access be declined, the information is recorded.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>InterRAI assessments are completed within the required timeframes and available to staff. InterRAI assessments were sighted in all resident files reviewed during the on-site audit. The service currently has three registered nurses who are interRAI trained and have the responsibility of having to ensure that all interRAI assessments are current.</p> <p>Residents' long-term care plans reviewed reflect the health problems as identified through the interRAI assessment process. All residents have current, long-term care plans in place to guide service delivery. Residents their families and the GP interviewed, are satisfied with the care provided at the facility.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Residents' long-term care plans reflect current conditions as identified through the interRAI assessments. The interRAI assessment identifies areas where there are increased health needs for the residents. The long-term care plans provide individual health goals which are based on the residents' needs as identified through the interRAI assessment process, with supporting interventions to guide staff in their service provision. The support plan evidenced for the YPD resident is person centred and developed with the resident.</p> <p>The ACM and RNs interviewed provided evidence of a sound understanding of the interRAI assessment process and how it is used to accurately identify the health risks, needs and goals of residents. Residents' records are integrated and continuity of care is evident.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Service delivery interventions are clearly recorded in the long-term care and in support of achieving the identified health goals. Care plans are individualised and specific to the residents' abilities. The resident files reviewed during the on-site audit showed evidence of residents having access to other health services in the community and choices regarding their healthcare. Residents and their families confirmed they are consulted and informed of health decisions regarding the care of the residents.</p> <p>Short-term care plans are developed for wound care (refer to 1.3.3.4).</p>

		<p>Interview with the GP stated their satisfactions with the level of care provided at the facility and confirmed competency of the clinical staff. The GP stated that there is effective communication between medical and nursing staff. The GP also confirmed being accessible after hours.</p> <p>Interviews with residents and their family confirmed their satisfaction with the care provided at the facility.</p> <p>The service has adequate stock of wound and continence products.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The facility provides an activities programme which aims to address the residents' needs, age and cultural preferences. Resident files reviewed during the audit process provided evidence of residents having been assessed by the activities coordinator (AC) and the physiotherapist. Each resident's activities assessment includes previous interests and abilities as well as current interests and abilities.</p> <p>The activities programme was reviewed. The AC plans monthly programmes which are then made available to all residents and their families. Attendance records are maintained. Each resident has their activities plan reviewed at six-monthly intervals or when the residents' condition changes, including YPD where relevant.</p> <p>Residents are encouraged to maintain links with the community through outings with family and van outings organised by the AC. Birthdays and other special days are celebrated. Activities were observed during the days of audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term care plan evaluations occur six monthly or when the condition of the resident changes. When the resident is not responding to treatment or care, the interventions are reviewed through interRAI re-assessment process and changes are documented as part of a care plan review.</p> <p>Staff confirmed they use the long-term care plans to guide service delivery. Residents and their families confirmed being consulted, however, they do not have opportunity to sign the long-term care plans in support of having participated in the care planning process (refer to</p>

		1.3.3.4).
<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 files reviewed during the on-site audit provided evidence of residents having access to other health and disability services in the community. The GP who is currently providing medical services to the residents has been in this role for just over a year. Interview with the GP confirmed visiting the service two to three times a week, is available to clinical staff at all times and can also be contacted after hours. Referrals to specialist appointments and other health services in the community were evidenced in resident files.</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>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage.</p> <p>Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There is provision and availability of protective clothing and equipment that is appropriate to the recognised risks, for example: goggles/visors; gloves; aprons; footwear; and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed. There have been no building modifications since the last audit.</p> <p>There is a planned maintenance schedule implemented. The following equipment is available: pressure relieving mattresses and cushions; shower chairs; hoists and sensor alarm mats. There is an annual test and tag programme and this is up to date with checking and calibrating</p>

		<p>of clinical equipment annually. There is sufficient equipment available for residents including YPD residents, to meet their needs. Personal equipment is only used by the resident that it belongs to.</p> <p>Interviews with staff and observation of the facility confirmed there is adequate equipment.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are decks and grass areas with shade, seating and outdoor tables.</p> <p>The prospective providers do not have any current plans for making environmental changes to the service.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members reported that there are sufficient toilets and showers.</p> <p>Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. In rooms requiring equipment, there is sufficient space for both the equipment, for example, a hoist, at least two staff and the resident, with the ability to include emergency equipment in the room, if required.</p> <p>Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite</p>

		<p>their own.</p> <p>There is room to store mobility aids such as walking frames in the bedroom safely during the day and night, if required.</p> <p>Where bedrooms are shared by two residents, privacy is maintained.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</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 service has lounge/dining areas in each wing of the hospital and other areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>The dining area has sufficient space for residents to move freely. Residents can choose to have their meals in their room.</p> <p>The facility includes places where young people with disabilities can find privacy within communal spaces. There is consideration of compatibility with residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</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>Laundry is completed on site, with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry. Laundry staff are required to return linen to the rooms. Residents and family members stated that the laundry service meets their needs. The laundry staff interviewed confirmed knowledge of their role, including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. Cleaners were observed to be vigilant on the days of the audit around keeping the trolley in sight.</p> <p>All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.</p> <p>Cleaners and laundry staff stated that they receive training from the</p>

		company that provides chemicals and this is documented.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>An evacuation plan was confirmed as being approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. A fire drill is provided for staff six monthly. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. There is always at least one staff member with a first aid certificate on duty.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency, including food, water, blankets, emergency lighting and gas barbeques. The services emergency plan also considers the special needs of young people with disabilities in an emergency</p> <p>An electronic call bell system uses display boards throughout the facility. There are call bells in all resident rooms, resident toilets, and communal areas, including the hallways and dining rooms. Call bells are monitored to ensure that they are answered promptly and that all are operational. Residents and family state that there are prompt responses to call bells.</p> <p>The doors are locked in the evenings. Staff complete a check in the evening that confirms that security measures have been put in place.</p> <p>There are surveillance cameras in place (refer to 1.1.10.4).</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature.</p> <p>There is a designated external smoking area for residents.</p> <p>Family and residents confirmed that rooms are maintained at an</p>

		appropriate temperature.
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The infection control coordinator (ICC) is also the ACM who is an experienced RN. The position description for the ICC role is signed by the ICC and kept on file. Review of the infection control programme included guidelines for the facilities' processes and the infection control manual. The ICC monitors infections using standardised definitions to identify infection surveillance.</p> <p>Infectious outbreaks or potential outbreaks are reported to management. Staff are made aware of changes in care processes to contain and prevent such outbreaks. Interview with the ICC confirmed the need for early identification of infections and understanding the importance of reporting outbreaks, as well as who to report outbreaks to.</p> <p>Infections are reported on during handover to ensure continuity of care for the individuals. Care interventions implemented for residents with infections, are recorded in the progress notes, however, the service is not currently using short-term care plans for the management of infections (refer to 1.3.3.4).</p> <p>The service has a recorded process for the prevention of exposing residents, providers and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility through the use of notices at the main entrance. Antibacterial hand gels are at reception and throughout the facility. There are also adequate hand washing facilities for staff, visitors and residents. When residents present with infections they are encouraged to stay in their rooms and families are asked to limit visiting areas to the resident's' room only.</p> <p>Interviews with the ICC and staff confirmed appropriate knowledge and skills in preventions of infections, including the importance of hand washing as standard precaution of infections. The infection control programme is documented and reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to</p>	FA	<p>The ICC has been in this role for seven months. The ICC formally reports to the facility manager at monthly meetings, however, they meet</p>

<p>implement the infection control programme and meet the needs of the organisation.</p>		<p>daily and concerns about infections will be raised at the daily meetings, should this occur.</p> <p>The ICC collates infection control data and benchmarking occurs against similar facilities. Monthly reports were reviewed, including graphs expressing trends and infections per 1000 bed days.</p> <p>There have been no infection outbreaks since the previous audit. The GP confirmed being part of the discussion that takes place when infections are a concern. The service has access to the infection control nurse specialists and microbiologist at the district health board.</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>	<p>FA</p>	<p>The infection control policy provides guidelines for organisation in how to minimise infections. The infection control manual consists of a suite of policies and procedures providing specific guidelines for the management of a variety of possible scenarios, including antibiotic use, wound management, blood and body-fluid spills, cleaning, laundry, standard precautions and outbreaks. The policies are appropriate to the facility's size and service requirements.</p> <p>The infection control programme forms part of the facilities' quality and risk programme.</p> <p>Observations during the on-site audit confirmed implementation of infection prevention and control procedures such as hand washing and the use of anti-bacterial hand gels.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection control education for staff starts at orientation and induction of new staff and ongoing training is provided through the facility's annual education and training programme. The ICC is responsible for the training of staff in the facility. The ICC attends training in infection prevention and control through updates at the district health board and e-learning, with the most recent training completed in August 2017.</p> <p>Resident education occurs as part of the daily care and encouragement of residents to wash their hands and use hand gels when appropriate. The ACM reviews infection control education, ensures education content</p>

		is current and maintains attendance records for staff.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The ICC is responsible for the surveillance programme for this service. Definitions of surveillance and types of infections are clearly defined and documented to guide staff. The ICC collates data at monthly intervals and the surveillance is appropriate for the size and complexity of services provided. Infection control alerts were documented on the individual residents' records reviewed.</p> <p>The infection control log is maintained by the ICC. Surveillance is carried out in accordance with recorded objectives, priorities, and methods as documented in the facility's infection control programme. All staff are required to take responsibility for surveillance activities.</p> <p>Interviews with staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers and progress notes. This was evidenced attending handover and review of the residents' files.</p> <p>The monthly analysis of the infections includes comparisons with the previous month's results, reasons for increase or decrease and actions taken to reduce infections. The analysis is included in the feedback that the ICC provides to staff.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service had three enablers and three restraints being used at the time of the on-site audit. The restraint policy includes clear definitions of restraint and enablers. Enablers are described in accordance with the Health and Disability Sector Standards requirements. The use of enablers is voluntary and the least restrictive option. Enablers in use were in the form of bedrails.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and</p>	FA	<p>The service has policies and procedures in place to guide staff in the management of restraints. The restraint register was current and maintained by the restraint coordinator, who is also an RN. Education records sighted evidenced staff received education on restraint</p>

<p>this process is made known to service providers and others.</p>		<p>minimisation and safe practice. Restraints included lap belts and bed rails. The restraint approval process is being followed and current consents were in place for the use of restraint.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Residents records reviewed for restraint use included consent, however, there have been no assessments recorded to ensure restraint processes meet restraint standards (refer to 2.2.3.2). The restraint consent records include opportunity to record restraint risks, however, the risks associated with the use of the restraint were not recorded (2.2.3.2). Culturally safe practice was maintained throughout restraint/enabler use, as per care planning.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>PA Moderate</p>	<p>The garden gate at the front of the property is locked and has a key pad access/exit for the safety of residents, however, the rationale and processes for the use of this environmental restraint has not been recorded in their policy or processes (refer to 2.2.3.2). Visitors and family are provided with the code to the gate on leaving the facility. The fire evacuation process and plan identify the gate as the assembly point during a fire or emergency evacuation. Staff will then open the gate depending on the type of emergency. Access through the gate from the street is facilitated by a button on the street side of the gate. Review of restraint management showed that restraint assessments are not consistently completed (refer to 2.2.3.2). Consent for restraint use is in place, however the restraint risks are not recorded. Restraint monitoring occurs, however, restraint monitoring is only recorded at the start and end of the day/shift (refer to 2.2.3.4). The restraints used at the facility are bedrails and lap-belts. Interviews with staff and review of long-term care plans confirmed alternatives to restraint use is considered prior to commencing restraint. Staff complete annual restraint competency training. The restraint register is up to date, recording the residents' name, the type of restraint/enabler being used, when it was initiated and opportunity to record the date of when it is discontinued. Staff are aware that advocacy services and support are available, the contact detail is documented,</p>

		and the services can be accessed when needed.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>All three of the restraints, which were in use at the time of the on-site audit, were commenced during January 2018. The restraints were all newly in place and evaluations have therefore not yet been implemented.</p> <p>Interviews with an RN confirmed evaluations of the restraints are to be completed at three-monthly intervals. The auditor sighted the evaluation forms intended for use at the time of the three-monthly restraint evaluation. Interviews with the RNs and the GP and review of the consent records for the restraints being used at the time of the on-site audit, confirmed that the GP, the RNs and the resident/their family are involved in restraint consent, evaluation and review processes.</p> <p>The restraint coordinator, RNs and the ACM maintain communication with families regarding restraint and enabler use.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint coordinator reports on restraint management at monthly meetings. Interviews confirmed that the restraint approval process forms part of the three monthly medical review. Interviews confirmed that review of restraints, includes effectiveness of the restraint, compliance with policy and procedures, adverse events related to restraint use, and the possibilities of discontinuing restraint is part of the three monthly restraint review process.</p> <p>Consent forms for restraint included timeframes for daily monitoring. Review of restraint consents, at the time of the on-site audit, showed these monitoring times were all recorded.</p> <p>Interviews with staff confirmed that monitoring of restraints is physically taking place according to the frequency as recorded in the consent records, however, monitoring is only recorded twice a day; at the beginning and the end of the restraint period (refer to 2.2.3.4).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	<p>PA</p> <p>Moderate</p>	<p>The facility has surveillance cameras in the communal areas and external areas for safety monitoring. Resident files identified that informed consent is signed for routine cares and procedures and the information to be collected; sharing of information with family; the listed routine procedures to be carried out; visiting personnel/students and use of a photographs. However, the form does not cover informed consent with regards to the use of surveillance cameras in the communal and external areas of the facility.</p>	<p>i) Informed consent forms signed by residents do not include the use of surveillance cameras throughout the facility.</p> <p>ii) The informed consent policy and procedure does not include guidelines for consent for resuscitation/advance directives and the surveillance cameras in the communal and external areas of the facility.</p>	<p>i) Informed consent forms to include the use of surveillance cameras.</p> <p>ii) Update the informed consent policy and procedure to include guidelines for consent for resuscitation/advance directives and the surveillance cameras in the communal and external areas of the facility.</p> <p>90 days</p>
<p>Criterion 1.1.10.7</p> <p>Advance directives that are</p>	<p>PA</p> <p>Moderate</p>	<p>Resident files identified that one form is used for consent for advanced</p>	<p>i) Advance directives in residents' files were signed by the GP.</p>	<p>i) Advance directives to only be signed by the resident who has</p>

<p>made available to service providers are acted on where valid.</p>		<p>directives and end of life care. The GP is signing advance directives and 'not for resuscitation' as one decision.</p> <p>The 'not for resuscitation' decision is made by the GP, however, there is no documented rationale to substantiate the reason.</p>	<p>ii) The 'not for resuscitation' consent does not specify that the 'not for resuscitation' decision made by the GP is as a result of the medical opinion of the GP.</p>	<p>been assessed as competent.</p> <p>ii) When it is the GP's medical opinion that resuscitation is not advised, the document should confirm/state that this is a medical opinion.</p> <p>60 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>Eight resident files reviewed all showed timely initial care plans. InterRAI assessments were completed within three weeks of admission and are reviewed at three monthly intervals, or when the condition of the resident changes. The long-term care plans were reviewed for accuracy, comparing it to the outcomes of the interRAI assessments. Long-term care plans included goals and interventions supporting the needs of the residents. Each long-term care plan reviewed facilitated opportunity for the RN to sign and date the completed document and opportunity for the resident/family to sign as evidence of their participation in care planning. Six of the eight care plans reviewed were not signed by the RNs and none of the care plans were signed by the resident/family. Care plans were reviewed in a timely manner.</p> <p>Short-term problems, other than wounds, had no management plans. Staff recorded their own</p>	<p>i) Long-term care plans are not signed off by the RN completing the document and the resident or their family do not sign the long-term care plan in evidence that they participated in the care planning process and are informed in relation to the care of their loved one.</p> <p>ii) Short-term care plans are not being used for the management of short-term/acute problems, with the exception of wound management.</p> <p>iii) Wound care records were non-specific with regards to wound management and did not record all the information required to make informed decisions relating to wound care including the plan, monitoring and review, including progress/decline of wounds.</p>	<p>i) Long-term care plans to be signed off by the RN completing the document and the resident or their family to sign the long-term care plan in evidence that they participated in the care planning process and are informed in relation to the care of their loved one.</p> <p>ii) Short-term care plans to be used for the management of all short-term/acute problems.</p> <p>iii) Wound care records to be specific with regards to wound management. The assessment of the wound, the wound care plan and the monitoring records to be clearly identifiable and specific.</p> <p>90 days</p>

		<p>actions/interventions in the progress notes.</p> <p>Wounds are identified, managed and monitored, however, the assessments, plans and monitoring records were non-specific with regards to the problem, the goal, the plan and timeframes for the monitoring, review and management of the wounds. Information was duplicated across both processes, with little opportunity to clearly record progress or decline in the wound. Wound monitoring records were not specific to the condition of the wound at the time of the wound review, for example; the general appearance, size, depth, exudate, granulation, progress or decline of the wound are not consistently recorded to provide a clear record of how the wound is managed.</p>		
<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made: (a) Only as a last resort to maintain the safety of consumers, service</p>	<p>PA Moderate</p>	<p>The service keeps the front gate locked for the safety of the residents. The lock is operated by a key pad lock. This lock is considered environmental restraint and the rationale and processes for the use of this environmental restraint has not been recorded in their policy or processes. Visitors and family can access the code for exit at the front gate via reception. The area at the gate is also the assembly point, should there be a fire or emergency evacuation. Staff stated that they will</p>	<p>i) The environmental restraint (the lock on the front gate) is not currently included in policy or procedures.</p> <p>ii) Restraint assessments are not recorded.</p> <p>iii) Restraint risks (risk due to the use of restraints) are not recorded.</p>	<p>i) The environmental restraint (the lock on the front gate) rationale is to be included in policy or procedures.</p> <p>ii) Restraint assessments are to be consistently recorded prior to the use of restraint.</p> <p>iii) Restraint risks to be recorded.</p> <p>90 days</p>

<p>providers or others; (b) Following appropriate planning and preparation; (c) By the most appropriate health professional; (d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation.</p>		<p>open the gate depending on the type of emergency. Access to the facility from the street is facilitated by a button on the gate.</p> <p>Restraint assessments are not consistently completed. Staff obtain consent for all restraints used. The restraint consent records reviewed facilitated the opportunity to record restraint risks, however it is the risks posed if the restraint is not used, that were recorded. Review of long term care plans confirmed alternatives to restraint use is considered prior to commencing restraint, as confirmed during RN interviews.</p>		
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any</p>	<p>PA Moderate</p>	<p>Staff complete annual restraint competency training. The restraint register is up-to-date, recording the residents' name, the type of restraint/enabler being used, when it was initiated and opportunity to record the date of when it is discontinued. Staff are aware that advocacy services and support are available, the contact detail is documented, and the services can be accessed when needed. Restraint monitoring occurs, however it is not consistently recorded at every check. Monitoring is only recorded at the start and end of the day/shift.</p>	<p>Restraint monitoring is not recorded at every check.</p>	<p>Restraint monitoring to be completed at every check as identified in the consent record.</p> <p>90 days</p>

<p>advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.</p>				
--	--	--	--	--

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.