

# Eileen Mary Age Care Limited - Eileen Mary Retirement Complex

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Eileen Mary Age Care Limited
<b>Premises audited:</b>	Eileen Mary Retirement Complex
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 6 June 2018    End date: 7 June 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	57

# 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.

### Key to the indicators

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

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

## General overview of the audit

Eileen Mary Retirement Complex, which has been renamed Eileen Mary Residential Care Centre, provides rest home and hospital level care for up to 58 residents in Dannevirke. The service is privately owned and one in a group of three, with oversight by a general manager. The facility is managed by a facility manager and a clinical nurse leader. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contracts 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.

This audit has resulted in one area requiring improvement and relates to the three monthly general practitioner reviews.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination. The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

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

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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A business plan for the facility includes quality goals and business risks are identified. It also includes the scope, direction, goals, values and a mission statement of the organisation. Monitoring of the services occurs with information provided to the general manager and owner regularly. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved in quality improvement, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are 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

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents, was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested annually and calibrated as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained

## Restraint minimisation and safe practice

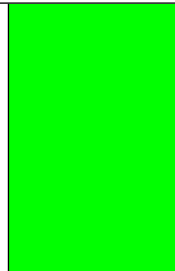
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. One resident was using an enabler and three were using restraints 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

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The infection prevention and control programme, led by 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)
<b>Standards</b>	0	49	0	1	0	0	0
<b>Criteria</b>	1	99	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	FA	<p>The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>	FA	<p>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.</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>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.</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>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. There are internal and external areas where residents and family can meet other than their bedrooms.</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>	<p>FA</p>	<p>The complaints policy and associated form meets the requirements of Right 10 of the Code.</p> <p>Information on the complaint process is easily available to residents and families throughout the facility and those interviewed knew how to access the process. In the October 2017, the Satisfaction Survey results (this was completed just as the current facility manager started in her role), 95% of respondents indicated that they felt comfortable raising concerns with 5 percent indicating some times, 40 percent most of the time, and 55 percent all the time.</p> <p>The complaints register reviewed showed that two complaints have been received so far in 2018 and that the actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible. Correspondence with complainants was respectful and detailed in relation to the issues which were raised.</p> <p>The facility manager is responsible for complaints management and follow up. During interview, she demonstrated a sound understanding of her role in relation to complaints management. Similarly, all staff interviewed confirmed a good understanding of the complaint process</p>

		<p>and what actions are required of them in their roles.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in the main areas together with information on advocacy services, how to make a complaint and feedback forms.</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>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence, for example, attending community activities, and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<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>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. The clinical nurse leader interviewed reported that there is one resident recently admitted who affiliates with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is no specific current Māori health plan, however all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and evidenced and integrated into long-term care plans with input from cultural advisers within the local</p>

		community as required. Staff supporting residents also acknowledge the wairua, aroha, turangawaewae, whanaungatanga, tapu/noa, mana, manaaki and kawa of the resident and their whanau. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. The whanau and resident were not available for interview.
<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	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. The resident satisfaction survey confirmed that individual needs are being met.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
<p>Standard 1.1.8: Good Practice</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, physiotherapist, diabetes and cardiac 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 and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the knocking on resident's doors before entering and day to day conversation between staff, residents and family/whanau and visitors at the time of audit.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<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 know how to access interpreter services, although reported this was rarely required due to all residents able to speak English. Three residents have been identified with a significant sensory impairment, and appropriate resources and equipment have been implemented to support the residents to maintain their independence.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Eileen Mary Residential Care Centre (Eileen Mary) is one of three aged residential care facilities owned privately by the same person. The group of three facilities is managed by a general manager who is based in Fielding. The general manager was available onsite during the audit of Eileen Mary.</p> <p>There is a business plan which is reviewed annually and includes the purpose, values, scope, direction and goals of the group. The documents describe annual objectives and the associated operational actions. A sample of the quarterly reports against the business plan which are sent to the general manager were reviewed. These showed adequate information to monitor performance is reported including occupancy, staff satisfaction, resident quality of life measures, training, and emerging risks and issues.</p> <p>The service is managed by a facility manager who is a registered nurse and maintains her annual practising certificate. She has worked in aged care since entering nursing in 2000 and was appointed to a clinical nurse leader role in 2010. In 2015 she became a facility manager. With a previous employer she completed a range of management and leadership training and maintains her clinical nursing qualification. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending relevant training made available</p>

		<p>by her employer and through the MidCentral District Health Board (MCDHB)</p> <p>The service holds contracts with the MCDHB for the provision of rest home and hospital (geriatric) level care, a day programme, respite care (one bed) and health recovery (one bed). They have a SEQUAL contract with the Manawatu Hospice for the provision of Supportive Education and Quality Palliative Care, however provision of services does not commence until September 2018.</p> <p>On the first day of the audit 57 residents were receiving services under the contracts held by the facility. Forty two residents were receiving rest home care, with one of these being a respite resident. Fifteen residents were receiving hospital level care.</p> <p>All 58 beds at Eileen Mary Residential Care Centre are certified for 'dual use' care (that is both hospital and rest home level care). This covers the 38 rooms and the 19 License to Occupy (LTO) care suites.</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>When the facility manager has a short absence from the facility the clinical nurse leader carries out the role under delegated authority. During longer absences a facility manager from one of the other facilities in the group, or the general manager, will take on the role.</p> <p>The clinical management is overseen by the clinical nurse leader who is an experienced registered nurse in the aged care sector. She has worked at Eileen Mary in this role for 18 months and has support and mentoring from the facility manager and other staff within the group. She can take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</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>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes an annual business plan which includes quality objectives, such as, Eileen Mary being the provider of choice, enhancing residents' quality of life and being an employer of choice. Within these high-level goals, there are operational activities which include the management of accidents, incidents and complaints, internal audit activities, a regular resident satisfaction survey, monitoring of clinical indicators (eg, infections and wounds, use of restraints and enablers, and falls).</p>

		<p>There are monthly meetings of all qualified nursing staff, the quality committee, auxiliary staff and a combined staff meeting for all staff members. Meeting minutes were reviewed and confirmed that this range of meetings is held regularly, there is good attendance by staff, there is review and analysis of quality indicators and that related information is reported and discussed as is appropriate. Collated accident, incident, complaint and other data from quality indicators is presented to staff members in graphed form.</p> <p>Staff reported their involvement in quality and risk management activities through the meetings they attend and their roles. For some staff members this may include internal audit activities. When appropriate, corrective action plans are developed and implemented to address any areas which require improvement. If staff are unable to attend a meeting, the minutes are available for them to read and they reported having these available in the staff room.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey was completed in October 2017. It is noted that this was very shortly after the current facility manager commenced in the role. A comment from a respondent was "Our new manager is very approachable and caring." In survey results, 100% of respondents thought staff were either always or mostly approachable and friendly.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. This is managed by the quality coordinator based in one of the Fielding facilities. All documents seen during the audit were current, had been reviewed within the organisation's document review cycle and were available to staff electronically.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Both the general manager and facility manager are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p>
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<p><b>Standard 1.2.4: Adverse Event Reporting</b></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 manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident monitoring form. A sample of incidents forms reviewed showed these were fully completed, events are investigated, action plans developed and followed-up in a timely manner. Adverse event data is collated, analysed and reported to staff at meetings (as noted in standard 1.2.3) and to the general manager.</p> <p>The general manager and facility manager described essential notification reporting requirements and their individual responsibilities. They advised there have been and no notifications of significant events made to the Ministry of Health, or other external agency since the previous audit.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after three-months in the role and then annually period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The facility has included competency assessments into the training programme. Caregivers have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. Some staff have qualifications up to Level 4. A staff member within the group is an internal assessor for the programme.</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>



<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, which is shared by the facility manager and clinical nurse leader. Staff reported that good access to advice is available when needed.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of four weeks of rosters, including the week of the audit, confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All nursing staff hold first aid certificates so that at least one staff member on duty has a current first aid certificate. There is 24/7 RN coverage in the hospital.</p> <p>The layout of the facility is in wings which form a rectangle. The Licensed to Occupy (LTO) units are on one and half sides of the rectangle and are as close to the central nurses' stations as the other rooms. The facility is on one level and all parts of the facility are accessible from each other.</p>
<p><b>Standard 1.2.9: Consumer Information Management Systems</b></p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p><b>Standard 1.3.1: Entry To Services</b></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>	<p>FA</p>	<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</p>

		<p>process. The organisation seeks updated information from the NASC and/or GP 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 and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'pink envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed evidence of supporting documents required, documentation in progress notes and communication between the acute service, family and the facility. Family of the resident reported being kept well informed during the transfer of their relative.</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>	FA	<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 (using an electronic system) 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 weekly.</p> <p>Controlled drugs are stored securely in accordance with requirements</p>

		<p>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. Standing orders are not used. There were no residents at the time of audit who self-administer medications.</p> <p>The required three-monthly GP review is recorded on the electronic medicine chart, however not all GP reviews were up to date (see criterion 1.3.3.3). There is an implemented process for comprehensive analysis of any medication errors.</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 food service is provided on site by one of two cooks and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan (A grade rating) and registration issued by the Tararua District council expires 31 January 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has 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. 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 resident meeting minutes.</p>

		Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
<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>	FA	<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. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as 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 four trained interRAI assessors on site which includes the clinical nurse leader. The facility manager has commenced training and a further two new registered staff are booked for training in July 2018. The facility manager and clinical nurse leader also have management access. Residents and families confirmed their involvement in the assessment process.</p>
<p><b>Standard 1.3.5: Planning</b></p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's</p>

<p>meet their assessed needs and desired outcomes.</p>		<p>individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is good. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p><b>Standard 1.3.7: Planned Activities</b> 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 activities programme is provided by an activities co-ordinator, currently training to become a diversional therapist, and supports the residents Monday to Saturday 10 am – 4.30 pm.</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/whanau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive and stimulating.</p>
<p><b>Standard 1.3.8: Evaluation</b> Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections 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><b>Standard 1.3.9: Referral To Other Health And Disability Services</b></p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service is supported by</p>

<p>(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>		<p>a GP, 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 physiotherapy, the clinical nurse specialist and allied health specialists. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. The facility is supported by an after-hours service through the local hospital for advice, and for acute situations an ambulance is called, and the resident is transferred to the public hospital in Palmerston North.</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>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There were available options for containing infectious waste for disposal as well as for the appropriate disposal of rubbish and other waste.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. Interviews with cleaning and laundry staff members confirmed that they have sufficient protective clothing and equipment to be able to manage waste and hazardous substances. They able to access to training, and assistance if needed.</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>	<p>FA</p>	<p>A current building warrant of fitness is publicly displayed. This expires on 13 May 2019.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment is hazard free, residents are safe, and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident</p>

		<p>groups and setting.</p> <p>Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <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>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility.</p> <p>Eileen Mary has a combination of 19 LTO care suites which have a full, wet area bathroom and 38 rooms with ensuites. Of these rooms, 37 have ensuite toilets with a handbasin, and one bedroom has an ensuite with a shower, toilet and handbasin. In addition, there are five shared showers and additional toilets for visitors and staff members.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident's independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation.</p> <p>Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>Communal areas are available for residents to engage in activities. There are two dining rooms, a lounge area and an activities room with an indoor bowls table. All rooms are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</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 undertaken on site in a dedicated laundry by dedicated laundry staff. At interview a senior laundry team staff member demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. She was able to take remedial action if the laundry chemicals were not providing a good enough result and she</p>

		<p>is happy with the laundry products used at the facility.</p> <p>Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. In the 2017 satisfaction survey, 86% of respondents stated that the laundry staff always take good care of their clothes and 14% stated that they mostly take good care.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff are undertaking the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and the Environment Scan audit which is completed three times a year. So far in 2018, it had been completed in April and the results indicated that an appropriate service was being provided.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 27 September 2007. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in December 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures and the annual training programme includes topics related to fire, emergencies and evacuation training.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the number of residents at Eileen Mary. Water storage tanks are located around the complex and include a 12,000-litre emergency water tank and additional tanks on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed in the internal audit schedule and residents and families</p>



		<p>reported staff respond promptly to call bells. In the 2017 satisfaction survey, 57% of respondents stating that staff always responded promptly and 43% stated they mostly responded promptly. During discussions with the facility manager she stated that call bell response rates had been an issue for her when she first arrived, and she had made this a focus for all staff. Throughout the audit staff were observed to be responsive to bells and attentive to the needs of residents.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time during the evenings and unlocked in the mornings. A security company checks the premises at night if the external doors are opened without being unlocked.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. All rooms have natural light, opening external windows and a view outside onto garden or small patio areas. Heating is provided by gas central heating in residents' rooms and in the communal areas.</p> <p>Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the public health team, GP and pharmacy. The infection control programme and manual are reviewed annually.</p> <p>The facility manager/registered nurse with the support of another registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the staff and quality manager, and tabled at the infection control and quality/risk committee meeting. This committee includes the facility manager/IPC coordinator, clinical nurse leader, registered nurse, 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</p>

		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>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 eight months. She has undertaken training in infection prevention and control and 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 reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in May 2018 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</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 including regular tool box sessions 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 the facility had a</p>

		<p>gastroenteritis outbreak in November of 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>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastroenteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</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. Trends are identified from the past year and this is reported by the IPC coordinator and reported to all staff.</p> <p>The facility has had a total of 71 infections since November 2017. Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. The residents in 2018 have been offered the 'flu' vaccine with a 96 percent uptake.</p> <p>A summary report for a recent gastrointestinal infection outbreak in November 2017 was reviewed, with five residents and no staff effected. This 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>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical nurse leader is the restraint coordinator for Eileen Mary. She provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p>

		<p>On the day of audit, three residents were using restraints and one resident was using enablers. In all cases, the equipment in use was the least restrictive option.</p> <p>For the resident using enablers they were 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 interview with the restraint coordinator and the facility manager.</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 this process is made known to service providers and others.</p>	FA	<p>The restraint approval group 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>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	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 restraint coordinator described the documented process.</p> <p>Residents' files reviewed confirmed families/whānau are involved in the assessment process. The general practitioner is involved in the final decision on the safety of the use of the restraint. Each assessment identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. Restraints were only considered after all other options were investigated. 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>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds and involvement in activities and not using restraints wherever possible).</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>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<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. Evidence of involvement in the evaluation process was confirmed through appropriate documentation and notes on residents' files.</p> <p>Evaluation of restraint use covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. Examples of restraints being discontinued when they were no longer required were seen on one of the three residents' files.</p> <p>Interview with the restraint coordinator and the facility manager confirmed their understanding of the evaluation process and focus on minimisation of restraint use. This was supported by restraint approval group meeting minutes.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p>	<p>FA</p>	<p>The restraint committee undertakes a six-monthly review of all restraint</p>

<p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>use which includes all the requirements of this Standard. The restraint committee meets monthly and every six months their meeting includes a review of the overall use of restraints at Eileen Mary. Meeting minutes reviewed confirmed that this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families.</p> <p>Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the restraint coordinator and facility manager confirmed that the use of restraint is kept at a low level through implementation of the policies and procedures and their guidance.</p>
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## 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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>It was evident from staff interviewed that they knew the residents well. Family/whanau interviewed stated that they were happy with the care and communication provided. Medical input is sought as and when needed and care is changed as and when needed and responsive to the needs of the resident. However due to the location of the facility and accessibility and availability of the GP's, 20 (twenty) residents at the time of audit did not have an up to date GP review.</p>	<p>Not all residents had an up to date 3 monthly GP review.</p>	<p>Ensure that all residents have an up to date GP review (one or three monthly) as stipulated by the GP in the residents notes to meet contractual requirements and time frames.</p> <p>180 days</p>

## 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>A resident survey showed a reduced satisfaction of activities by residents from 91 percent in 2016 to 81 percent in October 2017. As a result, a corrective action was developed which included an initial full staff meeting to discuss the outcome of the survey. A review of the current activities at the time was undertaken, the calendar was redeveloped in colour, pictures were added, and the print made larger. The activities co-ordinator (who started at the facility in January 2018) meets with the facility manager on a weekly basis and visits the residents each morning to update the residents on what is going to happen that day and encourage participation.</p> <p>A survey of residents' satisfaction following the changed activities programme in May 2018 provided positive feedback, with residents highlighting that the activities are more attractive and interactive with</p>	<p>The facility's activities programme is rated as continuous improvement by demonstrating an ongoing review process, increased resident satisfaction with the way activities are initiated and developed in response to residents' feedback and increased participation in the programme.</p>



		emphasis on the increased interaction and involvement with community groups. The residents stated that they also enjoy and look forward to the activities co-ordinator visiting each morning and the calendar is now user friendly.	
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End of the report.