

Heritage Lifecare (BPA) Limited - Telford Rest Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Heritage Lifecare (BPA) Limited

Premises audited: Telford Rest Home & Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 24 January 2019 End date: 25 January 2019

Proposed changes to current services (if any): Reconfiguration of services to change twenty eight (28) rest home beds to be used as dual purpose beds. There are already 25 designated certified hospital level beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 41



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Telford Rest Home and Hospital provides rest home and hospital level care for up to 53 residents. The service is operated by Heritage Lifecare (BPA) Limited and managed by a facility manager and a clinical services manager. Both the facility manager and the clinical services managers have been appointed to these roles since the previous audit. 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 contract with the Taranaki District Health Board (TDHB). The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, management, staff, allied health providers and a general practitioner.

A partial provisional audit was also undertaken for a proposed reconfiguration of services to change 28 rest home beds to dual purpose beds providing both rest home and hospital level care. There are already 25 designated certified hospital level beds at this facility.

This audit has resulted in a continuous improvement rating in safe and appropriate environment in relation to providing a safe and accessible external area to meet residents' needs. There were no areas identified as requiring improvement.

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 are provided that 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 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. There is one complaint that is not as yet closed out.

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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Business and quality and risk management plans include the scope, direction, goals and values of the organisation. Monitoring of services provided to Heritage Lifecare (BPA) Limited is regular and effective. 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 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 supports safe service provision and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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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.

All standards applicable to this service fully attained with some standards exceeded.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken 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 reviewed and implemented new policies and procedures that support the minimisation of restraint. One enabler and two restraints were in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and thereafter every year including all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. 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.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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>	FA	<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>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Residents and family have access to different lounges, have access to the outside garden and seating areas which includes the middle court yard off the sun lounge.</p> <p>The facility has 'Skype' available via a portable electronic device to support residents and family to maintain regular contact and relationships.</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 complaints and concerns policy and associated documents meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that five complaints have been received over the past year and that actions taken, through to an agreed solution are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints 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 report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in the main reception area 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>	<p>FA</p>	<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.</p> <p>Residents are encouraged to maintain their independence through community activities, arranging their own visits to the doctor, 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>	<p>FA</p>	<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 services manager interviewed reported that there were no residents who affiliate with their Maori culture at the time of audit. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. The Maori cultural policy states that there is a specific current Māori health plan, and all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and would then be integrated into a resident's long-term care plans with input from cultural advisers within the local community as required. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</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>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example, spiritual beliefs. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All</p>

<p>harassment, sexual, financial, or other exploitation.</p>		<p>registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psycho-geriatrician 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 day to day discussions between staff, residents and relatives. One resident interviewed stated that staff when providing support with daily activities of living ensure that her privacy is maintained at all times. Staff were observed maintaining privacy.</p>
<p>Standard 1.1.9: Communication 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>As a result of only ten of 43 relative satisfaction surveys in October 2018 being returned, a corrective action plan was developed to ensure that all 'next of kin'/Enduring power of attorney (EPOA) contact details for residents were up to date. It was found that seven of the 43 contact details for residents were incorrect. All contact information for all residents has now been updated and re-entered into the database.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English and staff being able to provide interpretation as and when needed. The clinical services manager interviewed stated that a 'tool box' session and communication cards were developed for a resident (now deceased) who was unable to verbalise their needs, but able to point to the cue cards.</p> <p>There are three residents who have a significant sensory impairment. Long term care plans showed interventions and equipment provided to promote ongoing independence, communication and support.</p>

		<p>For example, staff communicated with 'yes, no' questions, and use clear slow speech providing time for the resident to respond. Staff ensured that all furniture moved in a resident's bedroom was replaced back exactly, and staff knock on the resident's door and introduce themselves. Staff interviewed knew the residents well.</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>	FA	<p>The strategic and business plans are reviewed annually and outline the purpose, values, scope, direction and goals of the organisation. The business plan was reviewed for 2018 to 2019. The documents described annual and longer term objectives and the associated operational plans. A sample of weekly and monthly reports to the organisation's support office showed adequate information to monitor performance is reported including financial performance, emerging risks and any issues.</p> <p>The service is managed by a facility manager who is experienced in the aged care sector and has been in this position since 30 July 2018. Responsibilities and accountabilities are defined in a position description and individual employment agreement. The facility manager confirmed knowledge in the sector, regulatory and reporting requirements and maintains currency through attending leadership education at the Taranaki District Health Board (TDHB).</p> <p>The facility manager and the clinical services manager were interviewed in relation to the proposed change to reconfigure 28 rest home beds to dual purpose beds so that residents do not have to change rooms when their current level of care changes. The facility is well designed to facilitate and accommodate the proposed changes.</p> <p>The service holds contracts with the TDHB for up to 53 residents. On the day of audit there were rest home level care residents (26), hospital level care (13) and respite care (2) rest home level care residents, younger persons disabled (YPD) (Nil).</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>	FA	<p>When the facility manager (FM) is absent the clinical services manager (CSM) carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a senior registered nurse who can take responsibility for any clinical issues that may arise. The staff can be supported by the Careerforce educator (who covers two services). Staff can also obtain support from the HLL support office if necessary.</p> <p>The clinical services manager was interviewed and referred to the proposal request to the MoH to change 28 current rest home beds to dual purpose beds. The clinical manager is experienced to manage the additional clinical responsibilities should consent be obtained.</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 management of complaints and incidents, audit activities, a regular resident survey, monitoring of outcomes, clinical incidents including infections, pressure injury management and restraint minimisation and safe practice.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually in October. The most recent survey was poorly responded to by family/residents at the time. Another survey is scheduled for May 2019 earlier than the normal timeframe of October. Results were reviewed and documented.</p> <p>Policies and procedures cover all necessary aspects of the service and meet 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.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and developed mitigation strategies for HLL. The facility manager and facility quality manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</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 form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the support office clinical and quality team.</p> <p>Training is provided to all staff annually on the quality and risk management system including incident/accidents, complaints and hazards. The staff education plan was reviewed.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been 9 Section 31 notifications of significant events made to the Ministry of Health since the previous audit with one police investigation lodged on the 24 December 2018 remaining open.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>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 individual roles. Staff records reviewed show documentation of completed orientation and a performance review after three months and annually thereafter.</p> <p>Continuing education is planned on an annual basis including mandatory training requirements. A list of requirements was reviewed. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the TDHB. There is a Careerforce educator who covers two sites. Records are maintained electronically and were reviewed.</p> <p>Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. A schedule was displayed in the facility manager's office for the annual performance appraisals.</p> <p>The facility manager and the clinical; manager were interviewed in relation to the proposed reconfiguration of services. Orientation packs will be set up in readiness if additional staff are employed.</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>	<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 afterhours on call roster is in place with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four week roster cycle confirmed adequate cover has been provided, with staff replaced in any unplanned absence. At least one staff member is on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) coverage.</p> <p>A reconfiguration has been proposed to increase 28 current rest home level care beds to dual purpose beds being hospital and/or rest home. There are already 25 beds certified as hospital level care beds. Additional registered nurses and care staff will be increased as needed to cover hospital level requirements and to meet increased acuity as per the acuity tool used by HLL. There are adequate registered nurses (six inclusive of the CSM) available currently to provide the 24/7 cover required.</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>	<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>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>	<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 process. The organisation seeks updated information from the NASC and 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. 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>	<p>FA</p>	<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 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed appropriate documentation and communication between the facility, family, ambulance service and local hospital. Family of the resident reported being kept well informed during the transfer of their relative. While the resident remains in the local hospital, documentation in the progress notes also identified ongoing daily communication between the facility, family and local hospital.</p>
<p>Standard 1.3.12: Medicine</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>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 provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were six residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> <p>In regard to the proposed reconfiguration, the clinical services manager interviewed stated that there will be adequate staff levels to support all residents requiring assistance with their medications and all medical equipment/consumables.</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 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 awaits their verification audit and operates with an approved food safety plan and registration issued by the New Plymouth District Council which expires 30 October 2019. Food temperatures, including for high risk items, are monitored appropriately</p>

		<p>and recorded as part of the plan. All cooks and kitchen assistants have completed safe food handling.</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. The kitchen cooks all meals on site and serves directly to two adjacent dining rooms. Residents have the option of having their meals in their rooms. The residents and families also have access to self-service of tea and coffee making in the dining room.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>In regard to the proposed reconfiguration, the clinical services manager interviewed stated that there will be adequate staff levels to support all residents requiring assistance with their meals.</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>	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. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</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 a pain scale, falls risk, skin integrity, nutritional screening and depression scale and challenging behaviour, 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 services manager. A further two registered nurses are booked to complete their interRAI training. Time is allocated for the interRAI assessors to complete the assessments and to up-date the care plans. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated,</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>

and promote continuity of service delivery.		Care plans evidenced 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>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>	FA	Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed with 'great' care provided. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
<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>	FA	<p>The activities programme is provided by an activities co-ordinator who supports the residents Monday to Friday 8.45 am to 5.15 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 reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme very interactive and fun also stating that they are supported in individual specific activities of interest they have.</p> <p>Staff at the facility support the residents with a monthly gardening, 'care n craft', cards, baking, scrabble and 'men's clubs'. Residents are also supported to partake in the twice weekly walking train and weekly van outings. All residents have access to the activity calendar with residents reminded each day about the planned events when visited by the activities co-ordinator and are encouraged to attend and partake in the activities.</p> <p>All residents that present with behaviours that are challenging have had a 24-hour activity chart developed as a result of ongoing assessments, monitoring and evaluation to support all staff to be aware of activities and/or interventions that may reduce and minimise the challenging behaviour of the resident at that time.</p>

		The facility has a resident cat, goldfish, ducks and budgies of which the residents took part in the selection of and the developing of their new homes at the facility. The residents are encouraged to continue to look after their pets with guidance from staff.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, weight loss and trialling of restraint. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner with some residents supported by four independent GPs. 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 a speech language therapist, physiotherapist, wound nurse specialist and dietician. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training to staff. Material data sheets were available where chemicals are stored, and staff interviewed knew what to do should there be a chemical spill/event occur. A spill kit was available. There is provision and availability of personal protective clothing and equipment and staff were observed using this. In relation to the proposed reconfiguration there will be adequate supplies available of personal protective equipment available and the management of waste, infectious and hazardous substances

		will be appropriately managed by staff.
<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>	CI	<p>A current building warrant of fitness, dated expiry 20 July 2019, is displayed at the entrance to the facility.</p> <p>Appropriate systems are in place to ensure the residents' environment and facilities are fit for their purpose and are maintained. The testing and tagging of electrical equipment and calibration of biomedical equipment was current as confirmed in documentation reviewed, interviews with staff and observation of the environment. The maintenance person was not able to be present at this audit. The environment was hazard free, residents were safe and independence is promoted.</p> <p>A continuous improvement rating has been gained under this Standard for a specific quality improvement initiative project undertaken to further provide independence and safe use of an external area which is clearly now readily accessed and enjoyed by residents. External areas are safely maintained and appropriate to the resident groups and setting.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned. Residents reported that are happy with the environment.</p> <p>A partial provisional audit has been completed with this certification audit in regard to a reconfiguration proposal to change 28 rest home level care beds to dual purpose beds rest home and hospital level care beds provision. There are already 25 certified hospital level beds at this facility. The rest home rooms are all of generous proportion with adequate room for residents' personal belongings and additional equipment as required, such as shower chairs, wheelchairs, hoists and/or fall out chairs. Disability access is readily available internally and externally throughout the facility.</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. There are separate staff and visitor toilets available. In the hospital service area, there are two rooms with full ensuite. The rest home wing has a shared toilet and vanity between every two rooms, except for ten rooms. Signage is available. Showers and toilets are also in close proximity to all residents' rooms throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas and other equipment/accessories are available to promote resident independence.</p> <p>A reconfiguration proposal is supported as all communal toilets and showers meet disability requirements.</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 have single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p> <p>The reconfiguration proposal is acknowledged by managers interviewed who reported that residents will be provided with adequate personal space appropriate for the disabled, frail or long term hospital level care residents. The rooms are large for residents to move safely in their personal space/bedroom and to use mobility aids to promote independence and safety.</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 large lounges, a small activities/quiet lounge in the rest home and a separate whanau room in the hospital. There are two large dining rooms and a library with seating available. There is a recessed area for residents to make personal telephone calls. There is also a separate hair salon which is used regularly. There is disability access to the conservatory and outside courtyards from all wings.</p> <p>The proposed reconfiguration is supported with adequate age appropriate and accessible areas within the facility for residents to meet their relaxation, activity and dining 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. Laundry staff interviewed demonstrated a sound knowledge of the laundry processes. Personal clothing can be done by family or staff. All training is provided as part of the orientation process and is ongoing. The residents and family interviewed reported the laundry is well managed and their clothes are returned in a timely manner.</p> <p>There is designated cleaning staff who have received appropriate training. A contracted preferred provider checks all chemicals, supplies and equipment required for both services. This was able to be validated. A refillable chemical station was in a locked room. The cleaning trolley was stored in a locked room when not in use. The HLL cleaning schedules were followed by staff and achieved on a daily basis. Carpet cleaning as per the schedule sighted was undertaken. Water temperatures for the laundry were checked and maintained by maintenance staff.</p> <p>Facilities in the laundry and for cleaning are adequate to meet any increased needs in relation to the proposed reconfiguration.</p>
<p>Standard 1.4.7: Essential,</p>	FA	<p>Policies and procedures for emergency planning, preparation and response are displayed and known to</p>

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 30 January 2017. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 05 September 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, gas, water (supplies to meet the local Taranaki Regional Council requirements), blankets, mobile phones and a gas barbecue were sighted and meet the requirements for the number of residents at this facility. Portable water is stored appropriately and changed regularly annually. All equipment and resources are checked regularly, and checklists were reviewed. A copy of the emergency plan reviewed (15 January 2019) for the service inclusive of staff responsibilities (with clear photographs of equipment and how to switch off equipment in an emergency event), is provided in the allocated storage shed. Emergency lighting is available and is checked on a regular basis as verified in records reviewed. There is no generator on site but this can be arranged as needed.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a pre-determined time. Staff check the doors and windows during rounds of the facility. Security cameras are situated throughout the facility as a safety measure. Screens are checked and backup is available to management as required.</p> <p>The current essential, emergency and security systems in place at the facility are more than adequate to meet the needs for the proposed reconfiguration.</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>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening windows and all rooms in the courtyard area open into the courtyard with ranch sliders doors. Heating is provided by gas throughout the facility. Heat pumps are installed in communal areas. Areas were warm and well ventilated thorough out the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> <p>The proposed reconfiguration would not be affected in respect to natural light, ventilation and heating of all individual residents' rooms and/or the total facility.</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>	<p>FA</p>	<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 GPs and gerontology clinical nurse specialist as required. The infection control programme and manual are reviewed annually.</p> <p>A 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 clinical services and facility managers, and tabled at the quality/risk committee meeting. This committee includes the clinical services and facility managers, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>In regard to the proposed reconfiguration, the clinical services manager interviewed stated that there will be adequate staff levels to support all residents to continue to reduce and minimise the risk of infections.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role since August 2018. The clinical services manager interviewed stated that she will continue to support the IPC coordinator as she transitions into her new role. Both the clinical services manager and IPC coordinator have undertaken training in infection prevention and control as verified in training records sighted. Additional support and information are 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. The facility has also introduced five new infection outbreak kits and these are checked monthly.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in March 2018 and included appropriate referencing.</p>

<p>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>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was an increase in urinary tract infections in November 2018 and education was provided as part of a corrective action at the staff meetings. In August of 2018, a 'tool box' session provided staff with training on infection control more specifically reducing and minimising the risk of cross infection. Staff that are unable to attend staff meetings and/or teaching sessions are required to read the minutes of the meetings and education material provided and sign in acknowledgement that they have done so.</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 Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis 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 clinical services manager and reported to the facility manager, quality team and all staff at the facility.</p>

		<p>The facility has had a total of 45 infections from July 2018 through to and including December 2018. 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. Data is benchmarked within the organisation monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>The clinical services manager interviewed stated the facility has had no infectious outbreaks in the last 12 months.</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 have been recently reviewed and a new policy developed and implemented which meets the requirements of the restraint minimisation and safe practice standards and provides guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities. On the day of audit two residents were using restraints and one resident was using an enabler, which was the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the individual residents' records and from interview with staff.</p> <p>Restraint minimisation and safe practice was well understood by staff interviewed and managed in the event of a resident requiring the use of an enabler and/or a restraint. HLL protocol was followed. All staff have received appropriate education. The proposed reconfiguration will have no impact on the safe management of any restraints</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</p>	FA	<p>The protocol for the restraint approval group has been re-developed by the organisation quality and compliance team and is now made up of the HLL national manager clinical and quality, the clinical and quality improvement lead, two clinical managers and two restraint co-ordinators. The restraint approval group convenes twice yearly, approves restraint methods for the organisation, monitors restraint use and approves any policy change.</p> <p>It was evident from the review of residents' records and interview with the coordinator that there are clear lines of accountability and that all restraints in use have been approved and the overall use of restraints is being monitored and analysed. Evidence of family involvement in the decision making was on record as required. Use of a restraint or an enabler is part of the plan of care.</p>

made known to service providers and others.		
<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 restraints were documented and included all requirements of the Standard. A newly implemented form is to be used for all new residents entering the services. The RN undertakes the initial assessment with the restraint coordinator's involvement and input from the respective family/EPOA. The restraint coordinator interviewed described the documented process. Families confirmed their involvement. The assessment process identified the underlying causative factors, any history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure resident's safety and security. Completed assessments were sighted of the two residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<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 and low beds). When restraints are in use, frequent monitoring occurs to ensure the resident is safe. Records of monitoring had the necessary details. Access to an advocate can be arranged and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained and updated every month and reviewed at each restraint meeting. The register reviewed contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in restraint minimisation and safe practice at orientation and this is ongoing. Related topics, such as positively supporting people with challenging behaviours is provided. Staff have had the required training to manage the residents in the dementia service. Staff interviewed 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>	FA	<p>Review of the residents' records showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews six monthly or more often if required. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and the documentation completed as required.</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>	<p>FA</p>	<p>The current restraint committee undertakes a six monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports reviewed evidenced all restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint use, the competency of staff and the appropriateness of restraint/enabler education and any feedback from families, staff or allied health professionals is considered. A six monthly internal audit is carried out as part of the internal audit programme (schedule reviewed). Any changes to policies, as has recently occurred, are implemented as indicated. Data reviewed, minutes and interviews with staff and families confirmed the use of restraint is minimised.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	CI	<p>There are well manged accessible garden areas with even pathways, a gazebo, raised gardens and seating provided, suitable for the service groups and setting. A large central courtyard was not utilised at all by residents and families and described by residents as uninviting with the outdoor furniture not suitable for residents. After a meeting with staff, residents and families a project evolved with specific goals. Options were discussed with engagement of residents and family. A quality improvement action plan/form was completed. Residents were surveyed about their wishes and the results were discussed at a residents’ meeting with agreement reached on the development of the external space. The project was followed by the residents and work men and staff completed the project in the timeframe stated. An evaluation occurred two months after the project was completed with positive outcomes/feedback. At the time of this audit, residents and family members were seen to be using the area constantly and external activities were also being</p>	<p>The improvements to a previously unused outdoor area have resulted in an outdoor activities area where residents can relax with family and friends. This was important to the residents who were involved in the project planning and implementation. The fish pond area has provided the residents and their families with an area that is inviting, tranquil and relaxing. Residents have benefited from this project and are more independent and well-being has increased. The residents and staff ensure the garden area is maintained and the residents take pride in their roles, such as feeding the fish, which is monitored by a staff member. Furniture purchased is used which is appropriate to the service group and setting. Residents interviewed stated the seating was comfortable. Resident activities/functions are also held outside as</p>

		pursued.	part of the activities programme.
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End of the report.