

Senior Care Investment Limited - Fraser Manor Rest Home

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:	Senior Care Investments Limited
Premises audited:	Fraser Manor Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 May 2019 End date: 3 May 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	30

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
Yellow	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
Red	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

Senior Care Investment Limited Fraser Manor Rest Home (Fraser Manor) can provide rest home level care for up to 32 residents. The service is privately operated by a husband and wife team; one is the facility manager (FM) and the other is the chief executive officer (CEO). Two other members of the management team are the executive chef and the clinical manager who is a registered nurse. 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 district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, one visiting cardiac nurse from the hospital and the nurse practitioner.

This audit has identified two areas requiring improvement relating to complaints management and medication management.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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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 is no evidence of abuse, neglect or discrimination.

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

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

Organisational management

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Business and quality and risk management plans include the scope, direction, goals and vision of the organisation. As the FM works full time at the facility and the CEO visits the service at least three days a week they undertake regular and effective monitoring of services. The clinical manager and the executive chef support the owner/directors. All four members of the management team are experienced and suitably qualified for their roles.

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 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 medium or high risk and/or unattained 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.

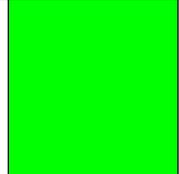
The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and 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.

The facility has a policy to support safe medication management. All staff administering medications 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 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 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. No enablers were in use at the time of audit. One bedside rail restraint was in use. There is lock on the front door with an exterior code pad. Anyone can exit the building but they need to use the code pad to enter the building for security reasons only. This is covered in policy and all residents and family members interviewed were aware of this. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Policy identifies that the 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.
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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	0	48	0	1	1	0	0
Criteria	0	99	0	1	1	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 provided with an information pamphlet and booklet which provides information on the residents' rights and responsibilities. Family members and residents interviewed stated that they were aware of the Advocacy Service, how to access this and their right to have support persons. Family and residents also stated that they felt comfortable in speaking with staff if they had any concerns or queries.</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 were always acknowledged when they visited and felt welcomed and comfortable in their dealings with staff.</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>	PA Low	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission. Residents and families interviewed understood the complaints process. One family member described a complaint they made and stated it was followed up promptly by the FM. She described the actions taken through to an agreed resolution. However, the complaints register reviewed showed that no complaints have been received since the provider has owned the business.</p> <p>The FM is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from 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 discussions with staff. The Code is displayed on the wall in the lounge area. Information on advocacy services, how to make a complaint and feedback forms were not located in the facility and/or readily accessible to residents and/or visitors/family/whānau but this was available on day two of audit (see criterion 1.1.13).</p>
<p>Standard 1.1.3:</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity,</p>

<p>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>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 by participation in activities of their choosing and/or partaking in regular community events and/or daily activities. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>In December 2008 the practice of handing over of the night shift to morning shift in the area of the kitchen ceased. Privacy of resident's information is now ensured by handover occurring in the nurses' station.</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 manager interviewed reported that there are two residents who affiliate with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. 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 evidenced and integrated into the resident's long-term care plans. Guidance on tikanga best practice is available. A Maori resident and whanau interviewed reported that staff acknowledge and respect their individual cultural needs and were very happy with the care provided at 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>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example, specific routines provided for the resident to promote wellness. Resident and family/whanau interviews at time of audit confirmed that individual needs are being met.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</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 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</p> <p>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, hospice/palliative care team, nurse practitioner, clinical resource nurse, community cardiac nurse specialist, mental health services for older persons, and education of staff.</p> <p>The facility is currently in negotiations with contracting a nurse practitioner to support the residents. The expectation is that the contract will be finalised in May 2019. In the interim, another nurse practitioner (NP) is visiting and supporting residents once a week and confirmed that staff have grown in skill and experience with the support of the nurse practitioner and clinical resource nurse from the community. 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 staff knocking on residents' doors before entering and day to day discussions between staff, residents and family/whanau/visitors.</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. Staff are also able to provide interpretation as and when needed and can use family members.</p> <p>Three residents were identified as having a significant sensory impairment. Appropriate equipment, resources and allied and staff support was evident in the residents' long term care plans, for example, talking books and clock, the use of white boards for written communication, staff assisting with mobility and meals and the reading of correspondence that residents received and support of the Blind Foundation.</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>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly meeting minutes and quality data reports showed that the owners are kept informed of issues. The FM works full time at the facility and can monitor performance on a daily basis. The CEO monitors financial performance, marketing, profit and loss.</p> <p>The service has a management team consisting of the FM, CEO, executive chef and clinical manager who is a registered nurse. All management team members hold relevant qualifications. The FM has a background in facility management in aged care over the past five years. She has 25 years' experience in finance both overseas and in New Zealand. The CEO has over 25 years' experience in human resources, operational oversight and planning. He holds a Masters of Divinity and worked as a psychologist specialising in behavioural management. The executive chef holds a degree in culinary art and has completed New Zealand Qualification Authority food safety papers. He has been in the role since June 2018. The clinical manager has worked at the facility since 2011, firstly as a health care assistant, then as a registered nurse from 2014. She attained the clinical manager role in 2017 and she holds a current nursing annual practising certificate. Responsibilities and accountabilities are defined in a job descriptions and individual employment agreements. The FM and clinical manager confirmed their knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at management and clinical education, forums and conferences.</p> <p>The service holds contracts with the Bay of Plenty District Health Board (BOPDHB) for rest home level care including respite care. Thirty residents were receiving services under the Age Related Residential Care contract at the time of audit.</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 FM is absent, the clinical manager with assistance from the previously employed facility manager carries out all the required duties under delegated authority. During absences of the clinical manager, the second registered nurse will oversee clinical aspects of the service. They are experienced in the sector and able to take responsibility for any clinical issues that may arise. The service has ensured succession planning has occurred to allow this transition to occur.</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 incidents, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, skin tears and falls.</p> <p>Meeting minutes and the staff communication book reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and implementation of corrective action. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (2018) showed that the two issues raised have been addressed by the service. For example, residents wanted more activities and the service has added an additional nine hours per week of activities by employing a fitness trainer to take regular exercise classes which residents stated they really enjoy. (These nine hours are additional to the regular activities undertaken by the activities coordinator). The other issue raised was related to medical services and this has been addressed.</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. They are developed and managed by a contracted service and personalised for Fraser Manor. 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 FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. An up to date hazard register was sighted.</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 FM and at staff meetings.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries. They advised there have been two section 31 notifications of significant events made to the Ministry of Health, on 18 July 2018 related to a resident's behaviour and one on 23 April 2019 regarding changes to medical cover. There have been no police investigations, coroner's inquests, issues-based audits and any other notifications made.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>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 showed documentation of completed orientation and a performance review after a three-month period. As all staff who were employed at the time the new owners took over the service have signed new contracts their annual appraisals are not yet due. The FM is aware this is an annual requirement.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The clinical manager is a trained and competent registered nurse who is maintaining her annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual interRAI performance appraisals. There is one other registered nurse who is undertaking her interRAI training at the time of audit.</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. Staffing levels meet the interRAI acuity level report findings. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. There is seven days a week, morning shift, registered nurse coverage. The two registered nurses share the on-call component of the role.</p> <p>There are dedicated kitchen staff seven days a week and cleaning staff 24.5 hours per week. Activities are undertaken by an activities coordinator for 21 hours per week and a fitness specialist works nine hours per week. The FM works Monday to Friday and is on call.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</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.</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>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 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>	<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 that the resident was assessed by the GP prior to transfer to an acute setting. Family were informed. The progress notes showed ongoing communication between the facility, acute hospital setting and family. 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</p>	<p>PA Moderate</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management 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>practice guidelines.</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>The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Controlled drugs are not always stored securely in accordance with requirements and checked by two staff for accuracy when administering.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. Vaccines are not stored on site.</p> <p>There were three residents self-administering medications at the time of audit. Appropriate processes are 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>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 an executive chef and supported by three cooks and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in January 2019. The report stated that the kitchen provided 'a high standard of nutritional care'. No recommendations were made.</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 and registration issued by the Tauranga City Council and expires 16 March 2020. A verification audit of the kitchen was completed on the 4 February 2019 by the Tauranga City Council with an 'acceptable outcome'. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The executive chef is qualified, and all kitchen staff have completed 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. An electronic system in the dining room presents the menu for the day.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion</p>

		and those requiring assistance had this provided.
<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. 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, incontinence, 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 trained interRAI assessor on site who is the clinical manager. Residents and families confirmed their involvement in the assessment process.</p> <p>The facility is currently being supported by the Western Bay of Plenty primary health organisation (WBOP PHO) Aged Residential Care (ARC) team in a quality initiative that supports an early alert and registered nurse assessment of unwell residents. Early statistics show a reduction in falls and urinary tract infections.</p>
<p>Standard 1.3.5: Planning</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>Standard 1.3.6: Service Delivery/Interventions</p>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>needs was evident in all areas of service provision. The NP 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>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by an activities co-ordinator who supports residents Monday to Friday for four hours a day. An exercise programme is provided for 30 minutes three times a week by a fitness specialist who is a trained fitness instructor. Regular one to one sessions are provided for residents who choose to not partake in group settings with exercises and/or activities of interest.</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 daily and as part of the formal six-monthly care plan review.</p> <p>A copy of the activities calendar is found on the lounge noticeboard and an electronic version of the calendar is located in the dining room. The residents also have a calendar provided for them in their bedrooms.</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/whānau are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find the programme of benefit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>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>Standard 1.3.9: Referral To Other Health And Disability</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a nurse practitioner (NP), residents may choose to use another medical</p>

<p>Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>practitioner. If the need for other non-urgent services are indicated or requested, the NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to mental health services for older persons, speech language therapist, clinical resource nurse. 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.</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 is provision and availability of protective clothing and equipment and staff were observed using this.</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 with an expiry date of 23 June 2019 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The service has a documented schedule of refurbishment with many items being completed monthly. One example is the lighting which has been upgraded to LED lights in all common areas. The testing and tagging of electrical equipment (17 April 2019) and calibration of bio medical equipment (30 July 2018) was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The external areas have been upgraded and as observed on the days of audit many residents enjoyed the shaded outdoor seating and dining areas.</p> <p>Residents confirmed they were 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. This includes five bedrooms with full ensembles and there are four bedrooms which share a toilet area between two rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident 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. There are two bedrooms which can have two beds but the service only uses these rooms for couples. At the time of audit all bedrooms were single accommodation. Where rooms are shared the service would gain both residents approval. 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 is a dining area and four lounge areas which include a quiet lounge and a television lounge. The areas 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>	FA	<p>Laundry is undertaken on site in a dedicated laundry as part of the care staff duties. Staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents</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>		<p>interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training.as confirmed in interview of cleaning staff and training records sighted. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through observation and internal audits.</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 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 23 August 2005 and there have been no changes to the building footprint since this time. A trial evacuation takes place six-monthly, the most recent being on 13 December 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, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for 50 people for 10 days as Fraser Manor is a nominated emergency welfare centre for the elderly who live in the area. There is a water storage tank located on the grounds of the facility and there is a generator on site. Emergency lighting is regularly tested.</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 predetermined time and there are close circuit cameras that focus on all external doors. The camera feed is monitored on the owners' cell phones. Residents and staff stated they feel safe at all times.</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 and opening external windows. Heating is electric in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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 NP and clinical resource nurse. The infection control programme and manual are reviewed annually.</p> <p>The clinical manager/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 facility manager and tabled at the monthly RN and full staff meetings.</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 for two years. She has undertaken training in infection prevention and control, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the NP 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,</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies are due to be reviewed in August 2019 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

safe, and appropriate/suitable for the type of service provided.		
<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 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.</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/ice blocks 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 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. Trends are identified from the past year and this is reported by the facility manager and also reported at RN and full staff meetings along with the results of the monthly surveillance programme. The monthly surveillance results are also posted on the notice board in the nurses' station and staff are required to sign when they have read the information. Twenty-four residents consented to the flu vaccine in May 2018.</p> <p>The facility has had a total of 23 infections since November 2018 through to and including April 2019. There were no infections for the month of November 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. Benchmarking does not occur.</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 service has a policy related to the lock on the main door, which cannot be opened from the outside without the key code. This is for safety reasons only as the front door is on a main road with very easy access from the street. The environmental restraint policy states that family members and residents are given the key code as part of the admission procedure. This was confirmed during interviews and observed on the days of audit. The door can be opened by anyone</p>

		<p>from the inside without the code at all times. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, one resident had a bedside rail restraint in place and no residents were using enablers. Policy identifies that enablers are the least restrictive and used voluntarily at the resident's request.</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 staff.</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 is made up of the GP and clinical manager along with the resident and family member. The approval group are responsible for the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, the resident's file and interviews with the coordinator that there are clear lines of accountability, that the bedside rail restraint has been approved, and the overall use of restraints is being monitored and analysed. Environmental restraint is discussed with intending residents and their family. All residents interviewed on the days of audit stated they could come and go freely and that they had no issue with the lock on the front door. The back door is accessible via a side path and is not lock during the day.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of restraint is part of the plan of care and identified in interRAI.</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 restraint coordinator undertakes the initial assessment with the knowledge of the GP and input from the resident's family/whānau/EPOA and the resident. This was confirmed in the file reviewed. The restraint coordinator described the documented process. The GP is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the resident's record review.</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 such as the use of sensor mats, low beds and regular resident checks.</p>

		<p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring are documented in the file of the one resident currently using a restraint. 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 it contained 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>	FA	<p>Review of residents' files showed that the individual use of restraint is reviewed and evaluated during care plan and interRAI reviews. The restraint coordinator reports all restraint use monthly to the FM and full reviews of individual restraint use is part of the annual multidisciplinary resident meetings.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. Documentation identifies family input and approval for continued restraint use.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint coordinator undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint findings are reported to the FM and at 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 in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. An annual internal audit that is carried out also informs the FM of restraint use over the year. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the restraint coordinator and the FM confirmed that the use of restraint has remained at one over the past 12 months.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>The service has a complaints register. There were no entries made by the current owners who have owned the business since July 2018. During interview, one relative clearly described a complaint/concern they had and that the FM had addressed this promptly and communicated the result to them. The actions taken have resolved all concerns identified by the relative.</p>	<p>One complaint/concern described by a relative is not documented in the complaints register.</p>	<p>Ensure the complaints register accurately records all complaints and the actions taken to address the complaint or concern.</p> <p>180 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>A resident is charted a controlled drug to be given at 8.00 pm. The registered nurse and care giver check the medication out of the locked cupboard in the nurses' station, document and sign for the medication in the controlled drug register. The medication is then locked in another cupboard in the nurses' station for one hour as the registered nurse has then completed their shift. At 8.00 pm a second care giver will also sign the controlled drug register and both caregivers administer the medication to the resident. The staff interviewed knew the resident well and when interviewed could recall the proper procedures required when administering and supporting a resident with a controlled drug.</p>	<p>Not all controlled drugs administration processes were undertaken in accordance with the facility's' medication policy and good practice in relation to administration, storing, documentation and checking of controlled drugs.</p>	<p>Provide evidence of safe medication management.</p> <p>7 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.