

Heritage Lifecare Limited - Raeburn Lifecare

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 Limited
Premises audited:	Raeburn Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 11 July 2019 End date: 12 July 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:	34

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

Raeburn Lifecare provides rest home, dementia and hospital level care for up to 54 residents. The service is operated by Heritage Lifecare Limited (HLL) and managed by a care home manager and a clinical services manager. There have been no significant changes to the service and facilities since the previous (provisional) audit in August 2018.

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, management, staff including a HLL clinical and quality lead person, a local needs assessment and service coordinator (NASC) and a general practitioner (GP). All the interviewees spoke positively about the care provided.

There were no areas identified as requiring improvement during this audit. Aspects of food/nutritional care and the service approach to reducing restraint were rated as continuous improvement. Each of the findings from the provisional audit in August 2018 had been addressed.

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 families are provided an information pack on entry to the service. Raeburn Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence and maintaining dignity and privacy. Staff receive training on the Code as part of the induction process and training is ongoing as verified in the training records.

Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreter service if required. Staff are provided with the information to make informed choices and to give informed consent.

Residents who identify as Māori have their needs effectively met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

Raeburn Lifecare has linkages with a range of specialist health care providers to support best practice and meet the needs of residents.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body 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 service 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

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.

Information is provided to the potential resident/family prior to admission and on admission a full service pack is provided. The multidisciplinary team is available to assess the resident's needs on admission. The registered nurse and the general practitioner

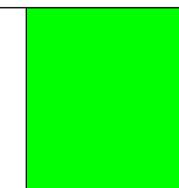
complete relevant assessments in a timely manner to meet the requirements of the services contract with the Waikato District Health Board. Care plans are individualised based on a comprehensive range of information and accommodate any new problems that might arise. Records reviewed demonstrated that 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.

There are planned activities to cover all services including the memory loss unit. Residents are provided with a variety of individual and group activities and maintain their links with the community. Twenty-four-hour activities are provided in the memory loss unit and activities are personalised to meet the individual needs of residents.

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

The foodservice meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents and families verified satisfaction with the meals provided.

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 offsite 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. Three restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. There were no enablers being used. 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 is led by an experienced and trained infection control coordinator who aims to prevent and manage infections at Raeburn Lifecare. The programme is reviewed annually. Advice can be sought from specialist infection prevention advisors if needed.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	2	99	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 obligation 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, respect and privacy. Training on the Code is included as part of the induction process for all newly employed staff and in ongoing training as verified in the staff training records. At the time of the audit staff in the memory loss unit were observed to offer choices and options to the residents and allowed time for the resident to respond. Family members of residents in the memory loss unit interviewed verified that choices were provided to residents and opportunities to attend activities in the rest home/hospital and to go out on outings were offered.</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</p>	FA	<p>Nursing and care staff interviewed understood the principles of informed consent. Residents' records reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Informed consent policies provide relevant guidance to staff. A separate van outing consent form was sighted and consent for the influenza vaccination was also in the records reviewed.</p> <p>Establishing and documenting enduring power of attorney (EPOA) requirements and processes for</p>

give informed consent.		residents unable to consent is defined and documented as relevant and was evidenced in all residents' records reviewed, including EPOA documents for the residents residing in the memory loss unit. Staff were observed interacting and gaining consent for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information is provided during the admission process on the Advocacy Service. A copy of the Code is provided in the admission to service pack. Posters and brochures related to the Nationwide Advocacy Service were displayed and available in the facility. Family members interviewed and residents spoken with were aware of the Advocacy Service and how to access this and their right to have support persons of their choice. Advocacy training is provided to clinical staff annually.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The staff encourage visitors to the facility. Family members interviewed stated they felt very welcomed by the staff and they felt comfortable in their dealings with staff. Residents are assisted to maximise their potential for self-help and to maintain links with their family in the community by attending outings, home visits with family, activities, shopping trips and entertainment provided at other facilities organised by the activities coordinator.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints 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 and those interviewed knew how to do so. The complaints register reviewed showed that two complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The 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 complaint investigations by the Office of the Health and Disability Commission or the DHB since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their	FA	Residents and their families 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 for residents entering any of the three services provided, being rest home, hospital and memory loss, and discussions were held with the registered nurses during the admission process.

rights.		The Code is displayed in areas of service delivery along with information on advocacy services and how to make a complaint and feedback forms are visible and accessible.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff were observed to maintain privacy and respect throughout the audit with residents. All residents are encouraged to maintain their independence by participating in community activities. Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Residents can choose their own GP, but most have the resident contracted medical officer for their medical oversight. Care plans included documentation related to the resident's abilities, and strategies to maximise their independence. The residents in the memory loss unit have access to a secure garden from the main dining/lounge area. The residents in the hospital and rest home have access to several lounges and outside areas where they can meet with their family/whānau especially in the warmer months of the year.</p> <p>Resident records reviewed confirmed that each resident's individual cultural, religious and social requirements, values and beliefs have been identified as part of the admission process. InterRAI information sighted also captures this information. This information is documented and incorporated into their respective care plans.</p> <p>Staff interviewed have a good understanding of what constitutes abuse and neglect. The policy reviewed had clear definitions to guide staff. Staff understood what to do if they suspected abuse/neglect and how to report this. Education is provided and confirmed in the training records reviewed. Advice is available if required from Aged Concern New Zealand and other agencies and contact details were available.</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 all service areas who identify as Māori to integrate their cultural values and beliefs. The principals of the Treaty of Waitangi are incorporated into the day to day practice, as is the importance of whānau. Policy reviewed guides and gives information about Māori beliefs in relation to illness, te whare tapa wha model of health and an outline of cultural belief experiences in relation to health in the context of Aotearoa New Zealand. Heritage Lifecare has a Māori Health Plan and Raeburn Lifecare has their own template and plan. There were no barriers identified for Māori people to access this service. Currently there is only one resident who identifies as Māori and three staff identify as Māori. The one Māori resident has a specific Māori health plan in the records reviewed along with the care plan. Guidelines on tikanga best practice was available and 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>	FA	<p>Residents and family members interviewed verified that they were consulted on their/their relatives individual culture, values and beliefs and that staff respected these. The residents' personal preferences and requests, required interventions and special needs if any were included in their care plans reviewed. The annual 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, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation at the facility. The orientation/induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses must complete Code of Conduct training as a requirement for their annual practising certificates. 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 if occurring. The individual Heritage Lifecare employment contract has a section on expectations and the Code of Conduct that all staff have to meet. This was sighted and verified in the personal staff records reviewed.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Raeburn Lifecare encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, mental health services for older persons, and education provided to staff. The general practitioner (GP) interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff interviewed 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 how the staff have transitioned, since September 2018, to Heritage Lifecare Limited (HLL) policies, procedures, residents' records and care plans. The acknowledgement of family visiting was verified and when interviewed family felt welcomed and able to participate with their relative's care. Meals were offered as well if the family member was visiting at lunchtime and this was appreciated.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirement of the Code. Residents and family members stated they were kept well</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>informed about any changes to their/their relative's health status and 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.</p> <p>Staff knew how to access interpreter services although reported this was rarely required due to residents at the time of audit able to speak English. Staff can provide interpretation as and when needed and include the use of family as appropriate.</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 Heritage Lifecare strategic and business plans outline the organisation's direction, purpose and values, and each facility develops their own set of goals and objectives to be achieved each year. The annual plan for Raeburn Lifecare contained detailed and time framed goals and evidence of progress being made toward these.</p> <p>A sample of monthly reports from the Care Home Manager (CHM) to their national office confirmed that the information provided is sufficiently detailed to monitor performance and includes narrative on any emerging risks and issues.</p> <p>The CHM who has been in the role for two years, has business qualifications and experience in managing health and disability services. Responsibilities and accountabilities are documented in that person's job description and individual employment agreement. Interview with the CHM and review of documents confirmed knowledge of the sector, regulatory and reporting requirements. This person maintains and updates their sector knowledge by attending regular DHB age care forums, national conferences and liaison with allied health staff. Interview and sighted records of professional development confirmed that compliance with the requirement in the aged related resident care (ARC) contract for managers to attend at least eight hours of training annually.</p> <p>The service has an ARC contract with the DHB for rest home, dementia and hospital level care. This includes provision of respite and palliative care. A new level of service provision titled Rest and Recuperation was trialled in 2018 at the request of the DHB and is now continuing under a memorandum of understanding. This provides for people being discharged from Waikato public hospital to stay for a maximum of 14 days before returning home.</p> <p>On the days of audit there were 34 residents on site. Fourteen of these were assessed at rest home level care which included one person for rest and recuperation, 13 residents were receiving hospital level care and seven residents were in the memory loss unit (MLU). One resident in the MLU was under the age of 65 years, having been assessed by a DHB psychogeriatrician as requiring that level of care.</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 care home manager is absent the Clinical Services Manager (CSM) carries out all the required duties under delegated authority with support and back up from the regional operations manager and the local clinical and quality lead person. During absences of key clinical staff, the clinical management is overseen by one of the other senior RN's who knows the residents and is able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, regular resident and relative satisfaction surveys, surveillance of infections and restraint and implementation of corrective action.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at monthly quality management team meetings, RN and staff meetings. Staff reported their involvement in quality and risk management by the quality data on display which is discussed with them regularly as well as the results from internal audits in their work areas. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey had only just occurred and results were not available on the audit days, but the number of written compliments received and the positive response from random interviews of family and residents indicated a high level of satisfaction. The service has also been lauded by the DHB for the successful management of a previously problematic resident who has resided at Raeburn for two years without complaint.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The CHM and health and safety representative 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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed from 2018 to 2019, showed these were fully completed, incidents were investigated,</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>action plans developed and actions followed-up in a timely manner to prevent recurrence. Adverse event data is collated, analysed and reported monthly to HHL national office for benchmarking. The CHM and the CSM review, comment and sign off all incident reports before they are uploaded in the electronic register for collation and analysis. Significant incidents and trends are discussed with all levels of staff to promote learning and identify remedial actions.</p> <p>The CHM fully understands and described essential notification reporting requirements. There have been two section 31 notifications made to the Ministry of Health, and the DHB since the previous audit. One involved a police investigation in December 2018 and the other was related to the behaviour of a new resident in the memory loss unit which occurred the week before audit. There have been no coroner's inquests, issues-based audits and any other notifications in this certification period.</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.</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 only staff allocated to work in the dementia care area have either completed or are enrolled to achieve unit standards in dementia care. Of the 17 caregivers, nine have completed the level 4 dementia series and eight are enrolled. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</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 members</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>interviewed supported this. 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 and there is 24 hour/seven days a week (24/7) RN coverage in the hospital.</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 resident' records reviewed. Clinical records were current and integrated with GP and allied health service provider records. 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. Labels are generated and used on the records sighted.</p> <p>The administrator interviewed prepares all records for admission and discharge and the system utilised was explained. The service is still in transition, changing all records over to HLL documentation. Records in use are stored appropriately in the nurses' stations and are out of public view. Additional residents' records are stored in a locked room on site and are accessible. Discharged residents' records are stored in envelopes which are clearly labelled and placed in document storage boxes. These are sent off site to a private contracted document storage company (preferred provider) for 10 years before being destroyed. An electronic records system is in place and records can be retrieved if required. The administrator is fully informed and was aware when archived documents are due to be disposed of as per the records reviewed. A destruction box for obsolete documents is on site and is collected in a timely manner or when full.</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 Service (NASC) which for this region is Disability Support Link (DSL). The screening/entry to service process is to determine any potential risks involved in the provision of services. The residents admitted to the memory loss unit have been assessed by a specialist. Prospective residents and/or their family members are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. When residents are admitted for respite care information is sought prior to admission from their GP or the NASC service for an update on their condition and/or needs.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that was provided to them. Records reviewed contained all relevant information about the resident including demographics, assessments, clinical records, diagnostic results and allied health input in accordance with contractual requirements with the Waikato District Health Board (WDHB). The admission agreements were signed and safely stored in the CHM office. Enduring Power of</p>

		Attorney documentation was verified in the residents' records in the memory loss unit. These had been activated as needed.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed effectively in a planned and co-ordinated manner. The GP facilitates the transfer with the assistance of the registered nurses if required. A transfer form is completed and DHB protocol is followed. Open communication between the services is ensured. Appropriate information is provided for the ongoing management of the resident. A copy of the medication record, care plan and resuscitation status if known is provided and the interRAI information is made accessible. Family of the resident are kept well informed and this is recorded in the resident's progress notes and family communication record.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Medication policies, procedures and guidelines are available to guide staff. A safe system for medicine management (using an electronic system) was observed on the days of the audit. The staff member observed demonstrated a clear understanding of the role and responsibilities related to medicine management. All staff who administer medicines have completed the required medication competency annually. The staff employed in the memory loss unit only give out medications in this unit and this is overseen by the registered nurse.</p> <p>The service has a contracted pharmacy. The medicines are pre-packaged and checked when delivered to the facility from the pharmacy by a registered nurse. Appropriate checks and balances are completed and weekly and six monthly stock checks are performed and were verified.</p> <p>The small fridge in the treatment room in the hospital is locked with a padlock. Due to the nature of medication stored at the present time. The room to the treatment room is also locked to ensure limited access.</p> <p>The GP interviewed reviews all medication records three monthly. Standing orders are not used at this facility. The requirements for pro re nata (PRN) medications are met. All known allergies/sensitivities to medicines are recorded on the electronic medication record and in the medical records for each resident.</p> <p>There was one resident self-administering medicine at the time of the audit. Appropriate forms and consents are documented to ensure this is managed in a safe manner.</p> <p>There is an implemented process for 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 the cook and a team of kitchen assistants and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter pattern and has been reviewed by a qualified dietitian within the last two years. Raeburn Lifecare has had a recent verification audit 19 June 2019.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislative requirements and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification and kitchen assistants have completed relevant food handling training. Fridge and freezer temperatures were accurately recorded. A large pantry was available which is not overstocked. All containers are clearly labelled and dated.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile is developed. The personal food preferences, special diets and modified texture requirements and portion sizes are made known to the kitchen staff and accommodated in the daily meal plan. Residents in the memory loss unit have access to food and fluids to meet their nutritional needs at all times. Special equipment to meet resident's nutritional needs is available and accessible if needed.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and residents' meetings minutes reviewed. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance have this provided in a timely manner after a quality improvement initiative which was implemented and is working well for the hospital level care residents.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a resident does not meet the entry criteria the local NASC service is advised to ensure the resident and family are supported to find an appropriate care alternative. This occurs for prospective residents/family and for residents in the facility whose needs change. If the needs of a resident change and they are no longer suitable for the services offered a referral for re-assessment to the NASC is made and a new placement service is arranged in consultation with the resident and family/whānau. 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</p>	<p>FA</p>	<p>Residents' records reviewed verified that recognised assessment tools are used, such as falls risk, skin integrity, nutritional screening and a pain scale, as a means to identify any deficits and to inform care planning. The care plans reviewed had an integrated range of resident-related information. All residents have a current interRAI assessment and this was verified electronically, and a copy</p>

manner.		obtained during this audit. The interRAI assessments are completed by one of three registered nurses interRAI competent including the CSM. Residents and families confirmed their involvement in the assessment process.
<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>Care plans reviewed reflected the care and 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 the care plans reviewed. For residents admitted to the memory loss unit, behaviour management plans are developed based on triggers and interventions of challenging behaviours.</p> <p>The care plans evidence service integration with medical and clinical progress records, activities records, and allied health professionals' input being clearly written, informative and relevant. Any change in care required is documented and verbally handed over to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans and are invited to the multidisciplinary review meetings (MDT).</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Policies and procedures are available to guide staff on clinical procedures. The attention to meeting adverse range of resident's individual needs due to the three services provided was evident in all areas of service delivery. The GP interviewed, verified that medical input is sought in a timely manner and medical instructions are followed. Care staff confirmed that care was provided as outlined in the documentation. Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals set and the plan of care. A range of equipment and resources was readily available suited to the levels of care provided.</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>	FA	<p>The activities programme is provided by one activities coordinator who is supported with regular contact with a trained diversional therapist holding the National Certificate in Diversional Therapy employed at another facility. A letter was sighted to verify the programmes are reviewed for each area of service delivery. The activities coordinator (previously a senior HCA who had completed the New Zealand Quality Authority (NZQA) frame work for level 4 health care of older persons), works Monday to Friday 8.30am to 4.30pm. The activities coordinator interviewed has been in this role for fifteen months. Activities are provided by the care staff in the weekends and resources are available and prepared in readiness by the activities coordinator.</p> <p>The weekly planners were displayed in each area of the home and on the notice board at the</p>

		<p>entrance to the facility. Photographs of previous recent events were also displayed.</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 assist with formulating an activities programme that is meaningful to the residents. The 24 hour clock/plan is used in the memory loss unit for all residents highlighting times of the day when activities may be required to meet the needs of the individual resident's presenting with challenging behaviours. The plans are reviewed as changes occur and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered on the programmes sighted. Residents and families are involved as much as possible in improving the programme through residents' meetings and feed-back provided.</p> <p>Residents interviewed verified that they enjoy the programme. One resident interviewed liked to be independent but will join in when he wishes to attend.</p> <p>Activities for the memory loss unit are specific to the needs and abilities of the residents living there. Activities are offered at times when residents are most active and/or restless. This includes one-on-one and distraction activities. There is a cat in the memory loss unit and one in the rest home. A church service is held every Sunday.</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>Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI re-assessment, or as residents' needs change. Where progress is different than expected the service responds by initiating changes to the plan of care. Challenging behaviour plans are evaluated by the registered nurses in consultation with the care staff who cover the dementia care service on a regular basis. Short term care plans are used consistently to manage any issues or problems and were evaluated as clinically indicated. The care staff interviewed knew to report any changes to the registered nurse on duty at the time or the CSM. Residents and families interviewed provided positive examples of their involvement in evaluation of progress and any resulting changes that may be required.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or</p>	<p>FA</p>	<p>Residents are well supported to access or seek referral to other health and/or disability service providers. The service has a contracted GP, but residents may choose to use another medical practitioner. Copies of referrals were sighted in the residents' records reviewed including to a speech language therapist, dietician, the Hospice Waikato, neurosurgery department, and physiotherapist and specialist clinics at the outpatient services WDHB. The resident and family are kept updated on</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>the referral process. Any urgent referrals are attended to immediately such as sending the resident in an ambulance to the WDHB 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.</p> <p>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 (expiry date 16 June 2020) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and are maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe, and independence was promoted.</p> <p>External areas were observed to be safe, well maintained and suitable for the resident groups and setting.</p> <p>Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required. The maintenance request records reviewed confirmed that all requests are attended to in a timely way.</p> <p>Residents said that 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</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility and additionally designated staff and visitor toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Monitoring of hot water temperatures occurs regularly, and the records sighted showed no temperatures above 45 degrees centigrade.</p> <p>A family member expressed disappointment about the slowness of promised upgrades to ablution</p>

<p>hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>areas in the hospital area. Visual inspection of all wet areas revealed some areas of degraded surfaces (window-sills and swollen boards) but these surfaces were not in contact with residents and not posing a significant infection control risk. Remedial paint work and removal of unfit for purpose building materials was scheduled and is occurring.</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>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is sufficient space to store mobility aids, wheelchairs 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>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. Each area for example, the memory loss unit, the rest home and the hospital, has its own dining and lounge areas. These were spacious and conveniently located to enable easy access for residents. Residents can access areas for privacy, if required. Furniture was in good condition and appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Only a small amount of laundry is undertaken on site (for example, hip protectors) otherwise all laundry is washed and dried offsite by a commercial laundry business. Residents and family members interviewed reported satisfaction with the laundry system and said their clothes are cared for and returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training as confirmed in interview with cleaning staff and review of their training records. Chemicals were stored in a designated and lockable room and where needed, chemicals were being decanted in to suitable and clearly labelled containers.</p> <p>The effectiveness of cleaning and laundry processes are monitored through resident and relative feedback and the internal audit programme. All areas of the facility were observed to be clean and staff demonstrated that the daily practices occurring ensure maintenance of hygienic, reliable and regular cleaning throughout the home.</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 staff in their preparation for disasters and describe 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 in 1988 and trial evacuations take place six-monthly with a copy sent to the New Zealand Fire Service. The most recent trial occurred in June 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. The onsite fire suppression systems are checked monthly by an appropriately qualified company.</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 54 residents and the Ministry of Civil Defence and Emergency Management recommendations for the region. The emergency lighting system was being regularly tested by maintenance staff.</p> <p>The call bell system was functioning on audit day 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. There have been no security incidents.</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 rooms provided sufficient natural light and had opening external windows. A number of bedrooms and all communal areas had doors that opened onto the outside gardens. Heating is provided by individual electric convector heaters in residents' rooms and there were heat pumps 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>There is a designated smoking area for the sole resident who smokes and the organisational smoke free workplace policy is known and adhered to by staff.</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</p>	<p>FA</p>	<p>The service has an implemented infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from the GP, pharmacy and WDHB as needed. The infection control programme and manual are reviewed annually.</p> <p>An experienced registered nurse is the designated infection control coordinator (ICC) whose role and responsibilities are defined in an HLL job description. Infection control matters, including surveillance</p>

<p>appropriate to the size and scope of the service.</p>		<p>results are reported monthly by the clinical services manager to the business manager and tabled at the quality/risk/staff meeting. The committee includes the care home manager, clinical services manager and representatives from all service areas.</p> <p>Signage is used around the facility. Visitors and staff are informed that if they are unwell, they should not enter the facility. The infection control manual kept in the staff room provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood their 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 ICC has appropriate skills, knowledge and qualifications for the role and was appointed 29 May 2019. The ICC has completed the online MoH training online and has a Diploma in Infection Control Management and has attended other relevant training/study days as verified in the training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and Public Health as required. The coordinator has access to the residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. There have been no outbreaks of infection since the previous audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>Infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies have been reviewed and include appropriate referencing.</p> <p>All staff were observed following organisational policies, such as appropriate use offhand-sanitisers, good hand-washing techniques and use of personal protective equipment such as gloves and aprons. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant</p>	<p>FA</p>	<p>Interviews, visual inspection and documentation verified staff have received education in infection prevention and control at induction/orientation and ongoing educational sessions. Education is provided by suitably qualified registered nurses and the ICC. Content of training is documented and</p>

<p>education on infection control to all service providers, support staff, and consumers.</p>		<p>evaluated to ensure it is relevant, current and clearly understood. A record of staff participation in the sessions 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 during the summer months.</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>	<p>FA</p>	<p>Surveillance explained by the ICC is appropriate to that recommended for long term care facilities and includes urinary infections, respiratory tract infections, skin, wound, eye, gastroenteritis and other known infections. The ICC reviews all reported infections, and these are documented. An infection data care plan/infection short term care plan is commenced and discussed at the staff handover between shifts to ensure early intervention occurs as per the plan.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify any trends for the current year and comparisons against previous years. Data is benchmarked externally within the organisation. The infection rate is low due to the decreased number of residents in the facility currently.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and responsibilities.</p> <p>On the day of audit, three hospital residents had bedrails in place for safety reasons, one of these was also needing a chair brief to be used when seated. Due to the resident's inability to consent these were listed as restraints. There were no residents using enablers. 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. The service has succeeded in reducing the number of residents with restraint interventions in place, this is further described in standard 2.2.5.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for</p>	<p>FA</p>	<p>HLL have terms of reference for the composition and responsibilities of the restraint approval group/committee and the practices at Raeburn Lifecare adhere to these. Approval for the use of restraint is coordinated by the CSM who is also the nominated Restraint Coordinator, the CHM, the</p>

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.		GP and the resident's representative. It was evident from review of restraint approval group meeting minutes, residents' files and interview with the CSM/restraint coordinator that there are clear lines of accountability, that all restraints have been approved, and that the overall use of restraints is being monitored and analysed. Interview with a family member confirmed their involvement in the approval, ongoing review and overall decision making. Safe use of the restraint was clearly described in the plans of care reviewed for the three residents with a restraint intervention in place.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of this Standard. The CSM/restraint coordinator undertakes the initial assessment with involvement and input from the resident's family/whānau/EPOA. The restraint coordinator demonstrated good knowledge of the process and a family member confirmed their involvement. The general practitioner confirmed that they were involved and informed about 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 records of all the residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example, the use of sensor mats, low- low beds and 'fall out' mattresses. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. The restraint register is kept updated and includes details about the resident, the type of restraint in use, the date of approval and commencement and review periods. The register logs the reasons for ceasing use of restraint.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the monthly restraint approval committee meetings. 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 documentation

		completed as required.
<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>Review of the monthly restraint meeting minutes confirmed these as a comprehensive quality review of all restraint use. This meets the requirements of this Standard. Trends in restraint use is reported to the quality and staff meetings. The restraint committee consider the overall use and type of restraint in place, whether all alternatives to restraint had been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback received from other parties. Internal audits on restraint also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the CSM the CHM and the clinical quality lead person, confirmed that the use of restraint has reduced from eight to three (more than 50%) over the past eight 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.

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 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>The menu plans were reviewed by the dietitian on 09 May 2019. A project was initiated after the CSM reviewed and analysed the individual monthly hospital residents’ weights and it was observed that seven of 16 residents were below the required weight per body mass index (BMI) requirements calculated. This result was discussed with the CHM and a decision was made to review the mealtimes and staff available to assist residents with their meals. A plan was developed and implemented to change the current meal service times. Starting on the 15 April 2019 a schedule was developed and implemented with stipulated times and who was to assist residents at the mealtimes. This included morning and afternoon tea designated times. This included all staff having input inclusive of the CSM, RNs, caregivers and activities coordinator. Findings were evaluated three months after the individual mealtime assistance was implemented routinely for hospital residents and the results showed that seven of 16 residents’ weight had increased within the three</p>	<p>Having fully attained this criterion the service in addition can clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken and based on these findings evidence the improvements to the service provision for hospital level residents. A significant issue raised from evaluating the information gained was identified as a focus of opportunity for improvement. The risk of unintentional weight loss was addressed for hospital level care residents</p>

		month period, four residents were overweight and three residents in the project had decreased due to chronic health conditions. Results were fed back to staff and to the quality staff at HLL head office.	and with changes made has positively improved the team approach and quality of care provided to meet the nutritional needs of individual residents in the hospital service.
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	CI	Interview with family, the restraint coordinator, review of all restraint documentation and visual observation confirmed that all restraint practice is safe, meets the requirements and that suitable alternatives to restraint are in place. The service has been conducting frequent reviews of restraint use and other related matters. One of the outcomes from these reviews was a planned focus on reducing overall restraint use. This has been successful.	The use of restraint has reduced by 50% in the past eight months following a coordinated and concerted effort to use alternatives.

End of the report.