

South Wellington Lifecare Limited - Vincentian Home for the Elderly Berhampore

Introduction

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

The audit has been conducted by 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:	South Wellington Lifecare Limited
Premises audited:	Vincentian Home for the Elderly Berhampore
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 January 2020 End date: 28 January 2020
Proposed changes to current services (if any):	Acquisition by South Wellington Lifecare Limited
Total beds occupied across all premises included in the audit on the first day of the audit:	45

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.

General overview of the audit

Vincentian Home for the Elderly Berhampore also known as Vincentian Home and Hospital provides rest home and hospital level care for up to 54 residents. South Wellington Lifecare Limited owned by Paul Renwick is proposing to buy this facility from the Wellington Catholic Homes Trust and this provisional audit has been performed as part of the acquisition process. It is proposed the service will be operated by South Wellington Lifecare Limited and managed by the current managers. Since the last audit the quality coordinator role has been dis-established and the manager's role has been divided into two shared roles. The residents, their families and staff have been informed of the proposed change in ownership. 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 an interview with the prospective client, review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, an allied health provider and a general practitioner.

This audit has resulted in no identified areas requiring improvement.

Consumer rights

Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is provided to residents and their families and is readily available. Residents' rights are upheld and aspects of these including personal privacy, independence, individuality and dignity are supported. 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. Residents and families are supported to make informed choices and relevant consent processes are in place.

Staff are provided with relevant training, and systems have been developed that would enable any resident who identifies as Māori to have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect nor any form of discrimination.

The service has linkages with a range of community services and specialist health care providers. These support the on-site services that are based on best practice and enable residents' needs to be more adequately met.

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

Organisational management

Business and quality and risk management plans included the scope, direction, goals, values and mission statement of the current Catholic faith based organisation. Monitoring of the services provided to the governing body was regular and effective. Two experienced and suitably qualified people manage the facility.

The current 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 was 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 recorded according to related legislation and guidelines. It is securely stored and not accessible to unauthorised people.

Continuum of service delivery

Relevant information is provided to potential residents and their family. Pre-entry referral and assessment processes for new residents moving into Vincentian Home for the Elderly Berhampore are in place.

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 according to their choices and maintains their links with the community.

An electronic medicine management system is in place. Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs and personal preferences catered for. Food is managed according to a current food safety control plan. Residents verified satisfaction with meals.

Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been 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

The current organisation has implemented policies and procedures that support the minimisation of restraint. Two enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Four restraints were in use by three residents. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

The infection prevention and control programme aims to prevent and manage infections. This is reviewed annually. The clinical manager and a trained infection control coordinator oversee implementation of the programme. 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 procedures and supported with regular staff and resident 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	50	0	0	0	0	0
Criteria	0	101	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>Vincentian Home for the Elderly Berhampore 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.</p> <p>Staff records, the orientation checklist and the staff training calendar verified that all staff employed undertake training on the Code as part of the orientation process and participate in ongoing training on residents' rights, with the most recent in-service education session being mid-2019.</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. Ongoing education on the topic is provided within training on consumers' rights. Informed consent policies and procedures provide relevant guidance to staff. Residents' clinical files reviewed show that informed consent had been gained</p>

		<p>appropriately using the organisation's standard consent form, which covers nine different aspects. Staff were observed to gain consent for day to day care and residents confirmed they always ask them about what they want and explain what they are about to do.</p> <p>Appropriate documentation of enduring power of attorney requirements was evident in residents' files reviewed. Processes for residents unable to consent are defined and these were also appropriately documented as relevant. Documentation in relation to personal preferences around resuscitation should the situation arise is clear and GP confirmation of cognitive competencies evident.</p> <p>There has been a focus on educating staff, family members and residents about advance care planning. One person has an advance care plan in place with others currently under development.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which includes information on the Advocacy Service. Posters and brochures detailing information about the nationwide Advocacy Service were displayed and available in the facility. Family members and the residents spoken with were aware of their right to have support persons and some residents referred to a talk from a person from the advocacy service during a recent visit.</p> <p>An independent church affiliated advocate visits at least weekly and residents are free to talk with this person at any time. Other residents stated they would talk to their families with a concern before they went to other people.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Community based entertainers and a team of volunteers visit the facility and share their skills and resources with residents to enhance the activity programme.</p> <p>The facility has unrestricted visiting hours and encourages visits from</p>

		<p>residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. The manager noted there is an open-door policy, although all visitors are requested to sign in the visitor book that they are in the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints 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 and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that five complaints have been received since the last audit 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, and deputy manager are 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) when they entered the service. Copies of the brochure about the Code, information on advocacy services, how to make a complaint and feedback forms are in the admission pack and available at the front entrance. The Code is available in any language or format, on request. Posters of the Code are displayed at the front entrance in both English and te reo Maori alongside a set of posters that have been developed by the service provider on residents' rights, their responsibilities and the values of the service. The prospective provider has previously been involved in other aged care services therefore has an understanding of residents' rights. There are no planned changes of current operational managers who are familiar with the Code.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit and the clinical manager explained the actions taken if a person is observed contravening a residents' right to privacy. All residents have their own private room.</p> <p>Residents are encouraged to maintain their independence by involving themselves in community activities, doing what they can themselves and participating in individual activities. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. A range of ethnicities and cultures were evident in the records with people from the Pacific Islands and of Polish descent having some personal preferences identified.</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. There were no reports from residents or family members interviewed of any incident of this nature. The clinical manager noted that an incident regarding an accusation of potential abuse had been fully followed up and reviewed to ensure any potential risks were identified and any possible improvements, including staff education, were addressed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There were no residents at the time of audit who have reported a specific cultural need. One person who identifies as Māori has strong support and considerable input from family/whanau, however they have declined the offer of using a Te Whare Tapa Wha Māori model of health for service delivery planning. Staff have received relevant Māori cultural training to enable them to support any resident who enters the services and identifies as Māori to integrate their cultural values and</p>

		<p>beliefs.</p> <p>The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available, although the manager informed that they are currently exploring their options due to changed circumstances of the current identified contact people. During interview, staff acknowledged the importance of whānau and the need to respect the individual cultural needs of any Māori residents.</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>Policies and procedures described the service provider's commitment to honouring the individual's culture, values and beliefs. Residents verified that they were consulted on their individual culture, values and beliefs when they entered the service and that staff respected these. Personal preferences, required interventions and special needs were included in the care plans reviewed, as well as in the assessments and planning completed by the occupational therapist responsible for the residents' recreation and activity plans. The resident satisfaction survey confirmed that individual needs are being met. More than five percent of the residents are of Polish descent and an even larger percentage who follow the Roman Catholic faith. People have options that enable their spiritual needs to be met with a Catholic mass held at the facility twice a month, an Anglican service fortnightly, weekly communion from a visiting priest and the opportunity to attend church or mass in the community as well. All services/mass on site are interdenominational.</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>Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of discrimination or exploitation likely to impact on residents. Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. New staff receive orientation in relation to professional boundaries, expected behaviours and the Code of Conduct. These expectations are integrated into the employment contract that each</p>

		staff person is required to sign. There was no evidence of discrimination or exploitation in the incident reporting records viewed.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through the senior staff maintaining their knowledge and skills, the availability of evidence based policies and procedures, input from external specialist services and allied health professionals including a local hospice, a diabetes nurse specialist, district nurses and the mental health services for older persons. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and all staff were responsive to medical requests.</p> <p>Staff confirmed they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the use of a qualified occupational therapist for the activities programme, the individualisation and personalisation of the residents' care plans, the ongoing reviews of care plans and the use of techniques such as tracer methodology to ensure systems are operating as expected. Staff demonstrated commitment and respect throughout the audit. The use of residents to lead some of the activities with minimal interventions from staff also demonstrated good practice.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Staff understood the principles of open disclosure, which are supported by policies and procedures that meet the requirements of the Code. A relative communication record sheet was in each resident's file reviewed. These showed contact is made with family following GP visits, any change in health status and any incident involving the person. Residents and family members who were interviewed confirmed they are kept well informed about any incidents or accidents and outcomes of regular and any urgent medical reviews. They also informed that they are invited to attend reviews of their care.</p> <p>Most residents are bilingual, and one person uses their first language at times. Staff knew how to access interpreter services, although</p>

		<p>reported this was rarely required due to all residents being fluent in English. Family members have assisted in the past when it was necessary. There is a facility wide focus on ensuring residents' hearing aids are working well to optimise their communication.</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>Vincentian Home for the Elderly Berhampore Limited is a company fully owned by the Wellington Catholic Homes Trust. The purpose, values, scope, direction and goals of the organisation are based on Catholic principles and are published throughout the facility. The manager described annual and longer term objectives and a sample of monthly reports to the Trust board members and quarterly trust board meeting minutes showed adequate information to monitor performance is reported including financial performance, staffing, health and safety, quality data analysis, bed days, and occupancy against targets, areas for concern and issues.</p> <p>The service is managed by a manager and deputy manager who job share so that between them they are contracted to work 40 hours a week. Both the manager who has been in the role for many years and the deputy manager hold relevant qualifications. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements. The manager and deputy manager confirmed knowledge of the sector, regulatory and reporting requirements and both are registered nurses who maintain currency through holding current annual practising certificates (APCs), attending Capital and Coast District Health Board (CCDHB) provider meetings and by involvement with the aged care sector.</p> <p>The service holds contracts with Accident Compensation Corporation (ACC), for accident related care and support and CCDHB under the age related residential care agreement (ARRC) for rest home and hospital level care (geriatric and medical – non acute), which includes respite and flexible funding for under 65 year olds. One resident was receiving hospital level cares services under the ACC contract and the remaining 44 people were receiving services under the CCDHB ARRC contract. The rest home and the hospital each had 22 people under the DHB ARRC contract at the time of audit.</p>

		<p>New provider interview January 2020: The new provider South Wellington Lifecare Limited is a newly created company owned by a person recently working at a governance level of an established New Zealand aged care provider (Heritage Lifecare Limited- HLL). This proposed acquisition of 54 aged care beds will be the first of a new business venture.</p> <p>The owner will perform the governance role and will initially have a very flat organisational structure with the assistance of the current facility staff and consultancy support from a registered nurse with aged care sector experience. The organisational structure described by the owner includes the addition of the nursing consultant.</p> <p>The transition plan is led by the owner who is very experienced and well qualified having been involved in and learnt from the 42 acquisitions completed by HLL in the last two years.</p> <p>Capital and Coast District Health Board have been contacted via email by the new provider regarding the proposed acquisition.</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 manager is absent, the deputy manager carries out all the required duties as per their job description. During absences of key clinical staff, the clinical management is overseen by the managers who are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>New provider interview January 2020: The new owner is working directly with current staff and it is expected there will be minimal changes to staffing, that is only one person will not be offered further employment due to a plan to outsource financial administration. Existing cover arrangements will remain in place, with access to the owner and the RN consultant. The new provider understands the needs of the different certified service types and understands the Age Related Residential Care (ARRC) agreement, including the responsibilities of the ARRC manager to meet section D17 of the agreement.</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 with an emphasis on inclusiveness, participation and engagement. This includes management of incidents and complaints, audit activities, regular resident and family satisfaction surveys, monitoring of outcomes and clinical incidents such as infections, falls and medication errors.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality/clinical meetings, health and safety meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, meeting attendance, incident reporting and training. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent surveys completed since the last audit showed an overall satisfaction with the services provided.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements. Policies are based on best practice and were current. The document control system is managed by the manager, and ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The manager 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>New provider interview January 2020: The prospective owner has no intention to change the policies currently used by the facility as he has ascertained, as part of due diligence process, that the facility currently has a four year certification with no partially attained criterion (PAs). He has had initial engagement with Healthcare Compliance Solutions Limited (HCSL) and is considering future investment in their policy/procedures system to ensure ongoing currency.</p> <p>Initially the quality plan currently used by the facility will be followed with a transition to new documents as they are due for review. The new provider expects reporting by the job-sharing facility managers,</p>
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		against the current plan to continue.
<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>	FA	<p>Staff document adverse and near miss events on the relevant coloured incident form that is green for falls and blue for other clinical incidents. A sample of incident 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 staff via the registered nurse newsletter, care team news, and meetings and to the board via the reporting process and meetings.</p> <p>The managers described essential notification reporting requirements, including for pressure injuries. They advised there have been two notifications of significant events made to the Ministry of Health, since the previous audit when a registered nurse was required to work a double shift.</p> <p>New Provider interview January 2020: There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of DHB contractual and legislative requirements including current health and safety compliance, and the need to comply with these. He has access to contracted subject matter experts to assist with addressing legislative or compliance issues.</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>	FA	<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 annual 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 with buddy support prepared them well for their role. Staff records reviewed showed documentation of completed orientation.</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 manager is the internal assessor for the programme. 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 suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate 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 24/7 RN coverage in the hospital.</p> <p>New Provider interview January 2020: The prospective owner intends to maintain the current staffing levels and skill mix. The facility currently has all the required policies and procedures to guide safe staffing levels and the new provider understands the need for this. The new provider says any future changes will be made as a result of recommendations by the external nursing expert.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes with the only exception being admission agreements, which are filed elsewhere. The records include interRAI assessment information entered into the Momentum electronic database. Records</p>

		<p>were legible with the name and designation of the person making the entry identifiable. Progress notes are entered each shift for hospital level care residents and at least once daily for rest home level care people.</p> <p>Archived records of current residents are held securely in a hallway cupboard on site. Those of deceased and former residents are transferred to the basement. All were catalogued and trackable. Residents' files are held for the required period before being destroyed.</p> <p>No personal or private resident information was on public display during the audit. Current residents' records were stored in lockable cupboards in the two lockable nurses' stations. Arrangements for numeric pad locks to be installed on the nurses' stations' doors, rather than the key locks, were made 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 older persons' 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 information package that is available for prospective residents and their families to read prior to deciding about entry to this facility is comprehensive. A manager or senior registered nurse is available to speak to people enquiring about entry into the service. The organisation seeks additional information about potential residents from referrers, the GPs and the hospital, for example, including updated information about residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them. Files reviewed contained completed demographic detail and relevant external and internal assessments and referral information. Signed admission agreements in accordance with contractual requirements are in a locked filing cabinet in the reception person's office. Service charges described in the admission agreements comply</p>

		with contractual requirements.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner. Although there were no respite care residents at the time of audit, the clinical manager described how other than ensuring the information is up to date for a person's return, the previous care plan and documentation is retrieved and used.</p> <p>The Vincentian Home for the Elderly Berhampore nurses use 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. A documented protocol describes the transfer of a resident going to another facility if for some reason, such as the person needing psychogeriatric care, the staff at the Vincentian Home for the Elderly Berhampore can no longer safely care for them. Such events are infrequent. Appropriate information is provided for the ongoing management of the resident.</p> <p>All transfers, whether temporary or permanent, are documented in the person's progress notes. Documentation reviewed of two residents who had required transfer to the local acute care facility showed that all essential information about the person and their care and support needs had been provided. Family of one resident reported being kept well informed during a transfer of their relative the previous year.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy was current and confirmed all aspects of medicine management were in line with legislative requirements and the Medicines Care Guide for Residential Aged Care.</p> <p>Policy documentation described staff responsibilities around medicine management and all staff who administer medicines, or who were authorised as medicine checkers, were competent to perform the function(s) they manage. An electronic medicine management system has been implemented to ensure the administration and monitoring of medicines are safe. The staff person observed administering medicines using this system demonstrated good knowledge and had a</p>

		<p>clear understanding of their roles and responsibilities.</p> <p>Medicines are supplied to the facility in a pre-packaged format from a contracted pharmacy. A registered nurse on the afternoon shift checks the medicines against the prescription and records this on the electronic record. All medicines that were checked were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs were stored securely both upstairs and downstairs in accordance with requirements and these are checked by two staff for accuracy when administering. The controlled drug registers provided evidence of weekly and six-monthly stock checks and accurate entries. Six monthly stocktakes are being maintained.</p> <p>The records of temperatures for the medicine fridges on both levels were within the recommended range.</p> <p>Prescribing practices were consistent with the requirements of the electronic system and included identification of the prescriber, the date of commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine record. Standing orders are no longer required.</p> <p>There were no residents who were self-administering medicines at the time of audit. Appropriate processes were described in policy documentation should this be required.</p> <p>There is an implemented process through the incident reporting system 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>Food services are provided on site by a contracted catering company. The menu follows summer and winter patterns and had been reviewed by a dietitian within the last two years, who confirmed it was in line with recognised nutritional guidelines for older people.</p> <p>The service operates with an approved food safety plan and registration, which has an expiry date of July 2020. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food</p>

		<p>temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Aspects of food storage that were found to be non-compliant with the food safety plan were addressed during the audit. Kitchen staff and cooks undertake ongoing safe food handling training modules as part of their employment requirements with the contractor.</p> <p>A registered nurse undertakes a dietary requirements nutritional assessment for each resident on admission to the facility and a dietary profile is developed. Kitchen staff receive copies of these, which were seen filed in a folder. The personal food preferences, any special diets and modified texture requirements had been made known to kitchen staff and were being accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs was available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal and those requiring assistance had this provided. It was observed that the main cook had a good relationship with the residents, ensuring individual preferences and needs were met and personally checking the residents' experience of the meal provided.</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 referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised accordingly to ensure the prospective resident and family are supported to find an appropriate care alternative. The facility manager noted that the team had only declined entry to one person for reasons other than no vacancy and that the situation had been discussed at length with the NASC coordinator.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of these situations occurring, in particular when people have needed more advanced dementia care services than could be provided in this facility, were discussed. There is a clause in the access agreement related to when a resident's placement</p>

		can be terminated.
<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>The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Further information is documented using a range of validated nursing assessment tools that were consistent with problems or concerns raised within the interRAI assessment processes. In addition to the initial nursing assessment and care plan, some of the assessment tools in use included a pain scale, falls risk, skin integrity, nutritional requirements and a mini mental. Residents and families confirmed their involvement in the assessment and reassessment processes.</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>The outcomes of the interRAI electronic assessment, the broader integrated assessment processes and other relevant clinical information from all members of the multi-disciplinary team were reflected in the care plans reviewed. Strategic use of assessment processes in the files reviewed had enabled the care plans to be focused and for the specific support needs of each resident to be met. Each care plan was dated, identified the problems and/or diagnoses, included associated objectives for each problem and described a list of interventions intended to address them.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>Examples of short-term care plans in the files reviewed were for infections, acute weight loss, skin tears and on return from acute services.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified that care provided to residents was consistent with their individual needs, goals and their plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP verified during interview that medical input is sought in a timely manner, that medical orders are followed, appropriate follow-up is taken, and overall care is of a very high standard. Care staff confirmed that resident care was provided as outlined in the documentation, which registered nurses took time to discuss with them. A range of equipment and resources was available, was suited to the levels of care provided and was in accordance with the residents' needs.</p> <p>Residents and family members expressed confidence in the care delivered and noted they do not want this to change following the purchase of the facility.</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 coordinated and mostly delivered by a qualified occupational therapist with some assistance from caregivers and volunteers.</p> <p>New residents are given time to settle before the occupational therapist undertakes three formal types of assessments, which collectively contribute to the resident's recreation and activity plan. The initial assessment is a life history, which is completed in consultation with the resident and whenever possible family members. A second assessment is an occupational therapy assessment, which primarily looks at mobility, toileting, eating, dressing, communication and social orientation. The third undertaken by the occupational therapist is a mini mental examination to check cognitive functioning. A personalised interests list is also developed.</p> <p>Once the residents' needs, interests, abilities and social requirements are ascertained, a personalised recreation plan is developed and integrated into the person's care plan. Activities assessments are reviewed on a daily basis by the occupational therapist, who discusses what worked and what was not so good with residents, in order to ensure the following week's programme is meaningful to them. The occupational therapist writes in each person's progress notes at least</p>

		<p>monthly, individual resident's activity needs are evaluated as part of the formal six-monthly care plan review and the occupational therapist participates in each person's annual multi-disciplinary meeting.</p> <p>Weekly activity planners are developed. Activities noted in two weeks of activity plans and personal recreation and activity plans reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents interviewed liked the various options within the programme, including the option not to attend if they did not feel like it, and stated they would never miss some of the activities. They confirmed they find the programme important as a way to get to know other people.</p> <p>The occupational therapist encourages residents to assist with the leadership of some activities and examples of this were sighted in operation with a person running the bowls and another who set up for Mass.</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. Caregivers informed they report any change in a person to the registered nurse on duty who decides the best action to take.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, and at any time when a resident's 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 skin and urinary tract infections, wound management and rehabilitation processes. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. This was further evident in the family communication record sheets.</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 disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</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 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or registered nurse sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the on-site physiotherapist, local hospice, the Accident Compensation Corporation, eye specialist, dentist and orthopaedic specialists. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. This is mostly done in consultation with the GP.</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 21 March 2020 was publicly displayed in reception.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with staff and observation of the environment. The environment was hazard free and resident safety was promoted.</p> <p>External areas are safely maintained and were appropriate to the</p>

		<p>resident groups and setting.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment.</p> <p>New Provider interview January 2020: The prospective owner has undertaken a due diligence process and as a result intends to make improvements, such as, a new facility van, minor refurbishments with new carpet and lounge chairs and redeployment of rooms.</p> <p>He is looking to have dual purpose beds in the future with bigger rooms, however there are currently no plans for environmental changes to the facility.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes all rooms having a hand basin, eight ground floor rooms having a full ensuite, and the remainder of the residents having shared facilities in close proximity to their rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. The eight rooms with ensuites on the ground floor although adequately proportioned to be used as hospital level rooms are used as rest home beds as they are too far from the nurses' station, with no line of sight.</p> <p>There is room to store mobility aids, and wheelchairs. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation,</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for</p>

<p>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>residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed and survey results showed that the laundry is managed well and residents' clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff undertake the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through satisfaction surveys, resident and family feedback.</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 were 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 5 February 2010. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 22 January 2020. 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 National Emergency Management Agency recommendations for the region. Water storage tanks are located around the complex. Emergency lighting is regularly tested.</p>

		<p>Call bells alert staff to residents requiring assistance. 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 by the ground floor staff.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and there is easy access to outside gardens and patio areas from communal spaces. Heating is provided by radiators run on gas 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>	FA	<p>The service implements an infection prevention and control (IPC) programme that is intended to minimise the risk of infection to residents, staff and visitors. Documented details of the programme sit alongside a comprehensive and current infection control manual. The infection control programme is reviewed annually and a copy of the annual report on management of the infection prevention and control programme for 2019 was sighted.</p> <p>The designated IPC coordinator was not available for the audit; however, the clinical manager/registered nurse who has been operating in this role during a recent extended absence of the coordinator was interviewed about implementation of the programme. The role and responsibilities of the IPC coordinator are defined in a job description, which includes a set of related goals and objectives. Infection control matters, including surveillance results, are discussed at infection control committee meetings and at quality/management meetings, where representatives from the different service areas including household services and health and safety are in attendance.</p> <p>Staff informed that during winter months, signage is placed at the main entrance to the facility requesting 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</p>

		work if they have been unwell and staff interviewed understood these responsibilities.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>Both the usual IPC coordinator and the clinical manager have appropriate skills, knowledge and qualifications for the role. The IPC coordinator undertook specific training for the role in 2016 and completed an online update in 2019. Additional support and information are accessible from the infection control team at the DHB and through the GP. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The clinical coordinator described the resources available to support the programme and any outbreak of an infection. There have been no infection outbreaks during recent years.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies and procedures include appropriate referencing and are due for their next review in August 2020.</p> <p>Care delivery, cleaning and laundry 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 were observed as being readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and at ongoing education sessions. Education is provided by the IPC coordinator, or the clinical manager, with a more recent focus on on-line training programmes for staff. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Staff were</p>

		<p>reminded of good infection control practice during the winter of 2019 when a number of residents contracted respiratory infections; although this was not deemed to be an outbreak. The 2020 training calendar is still under development and the draft version includes hand hygiene sessions, one on influenza management reminders, cleaning and laundry infection control practices and a review of management of a pandemic or outbreak.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing. Examples of this were sighted before the mid-day meals with assistance provided to residents for this to occur. Residents at risk of urinary tract infections are reminded of the need to drink sufficient fluids.</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 is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin/soft tissue, fungal, eye, mouth, gastro-intestinal, the upper and lower respiratory tract and an outbreak. Prescription of an antibiotic or anti-fungal is the determinant for inclusion of an infection in the infection surveillance data. The IPC coordinator and/or the clinical manager reviews all reported infections. These are documented and each has its own short-term care plan until it is resolved. Examples of these were viewed in residents' records reviewed, as were infection summary records in each person's file. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</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. The information is also described in regular staff newsletters, which have a specific section for this purpose. Graphs are produced that identify trends for the current year, and comparisons against previous years. The information is discussed at infection prevention and control meetings with a summary provided to the quarterly quality management meetings. Data has been being benchmarked via a system the service provider can no longer access and new ways of benchmarking infection rates against other similar</p>

		aged care facilities are being explored. Where data suggests best practise, processes have not been maintained, staff are reportedly reminded of their responsibilities.
<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 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, three residents were using restraints and two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews 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, made up of the restraint coordinator and the general practitioner, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial</p>

undertaken, where indicated, in relation to use of restraint.		assessment with the restraint coordinator's involvement, and input from the resident's family/EPOA. The restraint coordinator described the documented process. The general practitioner 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 records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	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.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and enough 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>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Staff interviewed confirmed their involvement in the evaluation process and families' satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if</p>

		the policy and procedure was followed and documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint committee undertakes a three-monthly review of all restraint use which includes all the requirements of this Standard. Three monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this included 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. Any changes to policies, guidelines, education and processes are implemented if indicated.

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, 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.