

# Heritage Lifecare (GHG) Limited - Brookhaven

---

## 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 (GHG) Limited

**Premises audited:** Brookhaven

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 15 September 2020 End date: 16 September 2020

**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:** 90

# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Brookhaven provides rest home and dementia care (rest home) for up to 92 residents. This service is operated by Heritage Lifecare, Golden Healthcare Group Limited (HLL (GHG)). There is an on-site manager and a registered nurse who are overseen by a five-member executive team including a general manager and a clinical manager. Residents and family members informed they are very satisfied with the services provided.

This certification audit was conducted against the Health and Disability Services Standards and the service provider's contract with the district health board. Audit processes included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, an allied health professional and a general practitioner.

The audit demonstrated that all requirements of the Health and Disability Services Standards are being met at the Brookhaven aged care facility.

## 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.
--	--	--

Staff at Brookhaven provide residents and their families/whānau with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these were observed to be respected. Services are provided in a way that supports personal privacy, independence, individuality and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents, and family/whānau is promoted and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and family/whānau with appropriate information required to make informed choices and give consent.

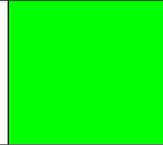
Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

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

Residents and family members are informed about the organisation's complaints policies and procedures. Complaints are investigated, any actions implemented, and responses provided efficiently. A complaint register is maintained.

## 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.

A strategic plan includes the scope, mission, vision, values, goals and monitoring systems within the organisation. Monitoring reports are provided to the executive management team on a regular basis. An experienced and suitably qualified person manages the facility.

The quality and risk management system is described within a quality plan and allied documentation. This includes collection and analysis of quality improvement data from which trends are identified and improvements are made. Feedback processes from staff, residents and families are in place and staff were familiar with, and involved in, the quality and risk system. Incidents and accidents are documented, related information is analysed, and corrective actions implemented when indicated. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support safe service delivery and management processes. These are reviewed regularly and were current.

The appointment, orientation and management of staff are based on current good practice. Staff are supported to undertake both internal and external ongoing training opportunities. Topics intended to support safe service delivery are identified and arrangements for delivery made. Regular individual staff performance appraisals are being completed. Staffing levels and skill mixes 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.
--	--	--

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family/whānau.

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

The planned activity programme provides residents with a variety of meaningful activities for both individuals and groups while maintaining links with the community.

Medicines are safely managed and administered by staff that are competently trained.

The food service meets the nutritional needs of the residents with special requirements catered for. Food is safely managed and residents expressed satisfaction with the meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
--	--	--

Various types of waste and hazardous substances are managed according to the service provider's policy and procedure documentation. Chemicals are stored safely in locked areas. Personal protective equipment is available and being used by staff. Laundry services are undertaken both on-site and by an external contractor. Cleaning and laundry processes are evaluated for effectiveness.

The facility provides a clean, safe, accessible environment for rest home residents, including those with dementia. There was a current building warrant of fitness and the facility has systems in place to ensure it is well maintained. Electrical equipment has been tested and bio-medical equipment calibrated as required. Communal and individual spaces are maintained at a comfortable temperature and there is sufficient room for people to move around easily.

Ongoing training on fire safety and use of emergency equipment is provided to staff. Fire evacuation procedures are regularly practised, and fire safety equipment is monitored according to requirements. Adequate supplies and equipment for use in an emergency are available. The call bell system is regularly audited, and suitable security systems are in place.

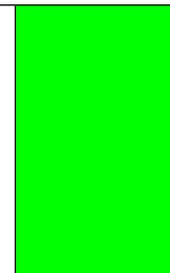
## Restraint minimisation and safe practice

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.
---	---	--

The organisation has implemented policies and procedures that support the minimisation of restraint. There were no restraints or enablers in use at the time of audit. Staff were aware that the use of enablers is voluntary for the safety of residents and in response to individual requests. A one-off use of a restraint in 2019 was well documented, investigated, reviewed and appropriate actions implemented. Staff demonstrated a sound knowledge and understanding of restraint and enabler processes.

## Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by a trained infection control coordinator, aims to prevent, control/contain, and manage infections. The programme is reviewed annually. Specialist infection and control advice is accessed as required.

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

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	Brookhaven has implemented 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 gave examples of how they integrated them into everyday practice, such as knocking before entering a resident's room. Care staff were observed providing options and maintaining dignity and privacy. Training is included during the induction process of new employees, and on an annual basis (due in October 2020).
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Family/whānau were informed of the importance of having Enduring Power of Attorney (EPOA) in place and activated through the admission information pack. Ten files reviewed had EPOA signed and accompanied by a Health Practitioner's Certificate of Mental Incapacity. In one case where EPOA was not in place at admission emails were sighted of communication of the importance of this occurring.  Informed consents were gained appropriately using the organisation's standard consent form. Advance care planning and establishing and documenting processes for residents unable to consent is defined and documented. Staff were observed seeking consent during daily cares.

<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/families are given information on the Advocacy Service. Brochures were also displayed at reception. Family/whānau spoken with were aware of the Advocacy Service, how to access this and their right to a support person but had not felt the need to access it due to the approachability of staff.</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 maintain their links with their family and the community by attending organised outings, visits, activities, and entertainment when appropriate. Family/whānau expressed that staff had kept them well informed of activities for the residents during the Covid-19 'lockdown', including video and phone calls. All residents have individual rooms where private conversations can take place.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns/compliments policy and associated forms meet the requirements of Right 10 of the Code and included the expected response timeframes. A risk management matrix and flow chart were included. Information on the complaint process is provided to residents and families on admission and family members and rest home residents interviewed knew how to file a complaint.</p> <p>Copies of completed complaint forms showed the complaints had been acknowledged, investigated, followed up and where relevant actions taken. This was confirmed during interviews with the facility manager and registered nurses, as well as in a complaint register, corrective action documentation and in quality and risk meeting minutes. The complaint register reviewed showed that six verbal and two written complaints have been received over the past year. These records further verified that the investigation processes and close out of each complaint had occurred within a timely manner. Benefits of including actions taken in the complaint register itself were discussed with the manager. Information on advocacy services had been supplied as appropriate.</p> <p>The clinical manager of the executive team, in consultation with the manager of the facility, is responsible for complaints management and follow up. In this facility, there is a proactive approach taken to any verbal complaints raised. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents/families/whānau interviewed were aware of the Code and had received opportunity to discuss it with staff. They received a copy of the Code, and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information pack. The Code was displayed in the main foyer and dining room, and brochures were available at reception, together with information on the Advocacy Service, and complaint/compliment forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents/families/whānau confirmed that they received services in a manner that has regard for their personal privacy, dignity and respect. Staff were observed offering choices and encouraging independence in activities of daily living. Care plans included documentation relating to the residents' abilities and strategies to maximise independence.</p> <p>Ten files reviewed demonstrated evidence of information on each resident's individual cultural, religious, and social needs. These were incorporated into their care plans.</p> <p>Staff understood the service's policy on abuse and neglect and were familiar with the process if signs were observed. Education sessions are held on abuse and neglect on a biannual cycle, along with management of challenging behaviours (due October 2020). Families/whānau interviewed had never witnessed any form of abuse, neglect or discrimination.</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>On the day of audit there were two residents who identified as Māori. They were well supported by staff to integrate their cultural values and beliefs into everyday life. At the time of audit, there was no cultural advisor for Brookhaven, but emails were sighted arranging a meeting with one that had been delayed by isolation restrictions due to Covid-19. A Māori health plan was available from the previous advisor. The two Māori residents had a cultural profile, resource booklet, information on the Treaty of Waitangi and a word/picture glossary of everyday words in their file. One Māori resident was interviewed and expressed satisfaction that their cultural needs were met in a sensitive manner. Cultural safety education was held on 22 January 2020 and included a quiz for staff to complete.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services</p>	FA	<p>Ten files reviewed confirmed that information was gathered on their individual culture, values and beliefs, that that these were incorporated into their care plans and staff were observed respecting these. Residents that are from a different culture have copies of beliefs/values/information and a glossary of words in their files. Residents/families/whānau expressed that needs were met in a sensitive manner. A cultural day is held annually.</p>

which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
<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 were observed to be treating residents in a respectful manner and calling them by name. Residents/families/whānau interviewed confirmed that staff were respectful and responded to residents in a dignified manner. The RN reported that there had been no incidents or complaints around abuse, neglect, or discrimination. During orientation staff receive education on professional boundaries and expectations required of staff in the Code of Conduct, and ongoing education occurs biannually. Staff are guided by policies and procedures and demonstrated a clear understanding of the process to follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies and input from external specialist services, for example, dietitians and a wound clinical nurse specialist. The general practitioner (GP) confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>The RN interviewed reported that he was well supported in his role, as the Golden Healthcare Group organisational structure has a senior RN providing oversight and guidance. External education is offered and access to online training is available.</p> <p>Brookhaven has created a sensory room where residents can listen to music in a calming environment.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Families/whānau stated they were kept well informed about changes to their relative's status and were advised in a timely manner about any incidents or accidents, as well as the outcomes of regular and urgent medical reviews. This was confirmed in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>The RN was aware of the process to access an interpreter but this had not been required due to multicultural staff and help from family/whānau when required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned,</p>	FA	<p>Brookhaven is an aged care facility operated by Heritage Lifecare (Golden Healthcare Group) Limited, otherwise referred to as HLL (GHG). Currently the facilities under the HLL (GHG) management structure use Golden Healthcare Group policies and procedures and have their own strategic business plan. The strategic plan 2020 – 2025 is reviewed annually. This provides an overview of the organisation and states its purpose</p>

<p>coordinated, and appropriate to the needs of consumers.</p>		<p>as being to provide a high standard of quality care in modern, purpose-built facilities. The scope of services provided in the various facilities is described and a set of goals refers to the achievement of external audits, ideal occupancies and ongoing monitoring of the various services provided. There is an overview of the structure of the organisation noting the executive team is comprised of the general manager; operations manager/human resources and compliance manager; administration manager; clinical manager and quality assurance manager. The maintenance manager and head gardener are responsible for managing all maintenance and gardening requirement for the organisation, including Brookhaven. A 'strengths, weaknesses, opportunities and threats' (SWOT) analysis has been undertaken and included in the strategic plan, which also includes a marketing strategy.</p> <p>The facility has a manager and a senior registered nurse who are responsible for ensuring the smooth and efficient management of the facility. Its mission is to provide quality care for the residents, catering for their physical, mental, spiritual, social, emotional and cultural needs, in a residence where they are cared for as unique individuals who merit the highest respect.</p> <p>A sample of minutes of executive team meetings, meetings of all GHG facility managers with the executive team and meetings with clinical staff, facility managers and the executive team were reviewed. The general manager met with the auditor and confirmed that these meetings complement monthly reports which enable him to maintain awareness of financial performance, emerging risks, and any issues a facility may be dealing with. In addition, the general manager described the ongoing links with the management of Heritage Lifecare.</p> <p>Brookhaven's facility manager has been in the role for five and a half years. Their responsibilities and accountabilities are defined in a position description and an individual employment agreement. As per their personnel file, the manager has had extensive management experience for over 15 years in another industry, as well as 10 years in a quality assurance management role. During interview, the manager confirmed knowledge of the sector, regulatory and reporting requirements. Records demonstrated the manager's attendance at a range of in-service training sessions in addition to attending contract related meetings with the DHB and aged care updates.</p> <p>The service holds contracts with the district health board to provide rest home care and dementia (rest home) care, including for respite. Ninety of the 92 beds were occupied on the day of audit with 50 being for rest home care and 40 dementia care. Two people in the rest home are funded via mental health contracts.</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</p>	<p>FA</p>	<p>A relieving experienced manager from the Golden Healthcare Group team will take over the management of Brookhaven when the manager has a planned absence, otherwise the senior registered nurses will take on management responsibilities and carry out required duties under delegated authority. Additional support is available from members of the HLL (GHG) executive team and from managers of other facilities within the organisation.</p>

<p>efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>Clinical management is overseen by other registered nurses who work in the facility during absences of key clinical staff. Additional support may be accessed from the clinical manager of the HLL (GHG) executive team. Registered nurses reported during interview that they feel well supported and the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Brookhaven uses the Golden Healthcare Group's (GHGs) planned quality and risk system that it is well documented (last updated 31 December 2019) and reflects the principles of continuous quality improvement. This is coordinated by an experienced quality manager who is also a member of the GHG executive team.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the executive management team meetings, at the organisational quality and risk team meetings and at Brookhaven management and staff meetings. Quality and risk meeting minutes included area reports as well as reports from each department including housekeeping, clinical, activities, for example. Other topics covered included internal and external auditing, incidents/accidents, health and safety/hazard management, training, emergency management and infection control. There was evidence of corrective actions being identified and followed through for any shortfalls, potential and actual risks being identified and managed, and of quality improvement projects being instituted. The manager is responsible for identifying quality improvement opportunities and for following these through to completion with the team; however, these had been interrupted by additional demands on the team's time due to the Covid-19 pandemic.</p> <p>Resident and next of kin/enduring power of attorney (for dementia care residents) satisfaction surveys are completed annually and the information is analysed. The most recent survey undertaken March 2020 showed 98% satisfaction in all areas. Some additional comments provided by participants has alerted the team at Brookhaven with some ideas about some things they can make improvements on. A staff survey undertaken August 2020 has also raised some suggestions that could improve things for staff, residents, and the environment. Staff confirmed they consistently receive updates on quality and risk data, have a representative from their department attend quality and risk meetings, complete forms such as incident forms, are involved in corrective action processes and receive education specifically about quality and risk processes. Three monthly newsletters are produced and are available to residents, family members and staff. These include updates and information about improvements, changes and activities at Brookhaven.</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 with the latest update being February 2020. A document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The clinical manager for the organisation reported working with HLL on a project towards combining Golden Healthcare Group and Heritage Lifecare Limited policies and procedures.</p>

		<p>A comprehensive risk management register for 2020 includes risk action plans and review processes. All projects and quality improvement initiatives have their own risk action plans. The manager and the quality manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. There is a health and safety manual available and the manager is familiar with the Health and Safety at Work Act (2015) for which the requirements have been implemented. Hazard registers are available and updated as required.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form according to organisational policies and procedures on adverse event reporting. The details are transferred into the organisation's electronic system. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions are followed-up in a timely manner. Adverse event data is collated, categorised, analysed and reported by both the manager at Brookhaven and by the quality manager at the Golden Healthcare Group level. This is benchmarked against other Golden Healthcare Group facilities and management meeting minutes demonstrated it is also reviewed at this level. Quality and risk meeting minutes for Brookhaven include summaries of these processes, any trends identified and any recommended corrective action or quality improvement follow-up. Information resulting from these analyses is shared with staff who confirmed during interview that they understand the graphs provided and find the updates useful.</p> <p>There have been no health and disability complaints, or significant events occur, since the previous audit a year ago; however, the manager described how they had met essential notification reporting requirements to the Ministry of Health for a respiratory outbreak, a pressure injury and a medication error. The DHB, especially the public health unit, has provided the manager and registered nurses with information and updates related to the Covid-19 pandemic.</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, pre-employment interviews and validation of qualifications and practising certificates, where required. Evidence of annual practising certificates has been retained for associated health practitioners including registered nurses, general practitioners and a physiotherapist, podiatrist, and dietitian. A sample of staff records were reviewed and confirmed the organisation's policies are being consistently implemented and records including employment agreements are maintained. Staff records and training processes are a component of the internal audit system.</p> <p>Policies and procedures on new staff orientation are available and there are a range of orientation checklists according to the different staff roles and responsibilities. All staff orientation includes the necessary components relevant to the specific role. Staff reported that the orientation process prepares new staff well</p>

		<p>for their role and timeframes are adjusted according to previous experience and the person's readiness to work independently. All staff records reviewed showed documentation of completed orientation checklists and initial competencies required.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements, which are clearly documented. A training schedule for 2020 was sighted and the manager informed that the development of workbooks on a range of training topics has facilitated their ability to ensure staff have remained up to date when they have been unable to attend a specific session and during the recent Covid-9 lockdown when trainers were not able to visit the facility. 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. A staff member within the wider organisation is the internal assessor for the programme. Staff working in the dementia care areas have completed the required education except for four newer caregivers who have recently commenced the process. Caregivers are being given the opportunity to undertake both level three (25 already have this) and level four (four already completed) of the national certificate if they choose and staff interviewed spoke positively about this.</p> <p>New staff undergo a performance review after three months. Annual performance appraisals are up to date for all staff who have been employed at Brookhaven for at least one year.</p> <p>Records confirmed that all four of the registered nurses working at Brookhaven have a current competency to undertake interRAI assessments and the fifth is enrolled in the next group. All are maintaining the required organisational and nursing council registered nurse competencies.</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 24/7. A separate rostering policy details these requirements at the facility level. The manager informed that staffing levels are altered in order to meet the changing needs of residents and reports of this having occurred were provided. All new staff are buddied until they are considered to be confident and competent by the manager.</p> <p>The manager is on duty Monday to Friday and is on-call 24/7 Monday to Friday. An assistant manager takes on this role Saturday and Sunday. Three registered nurses are rostered on morning duty Monday to Friday, two on afternoon duty for three days and one on two days. None are rostered night shift and weekends. A registered nurse on-call roster is in place for clinical enquiries outside of these duties. The organisation's clinical manager is also available for support and advice when necessary. Caregivers reported during interview that there is good access to advice when needed and that there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of three previous weeks of the roster, the current week plus one going forward confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Agency</p>

		staff is used as a last resort only. A list of staff with a current first aid certificate and their due date was sighted. The rosters detail the staff who have a current first aid certificate and all shifts have been covered accordingly. Similarly, staff with a current medication competency are identifiable on the roster and the person responsible for medicine administration on each shift is identifiable.
Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary consumer information was sighted in the residents' files reviewed. Clinical notes were current and included input from the nursing staff, diversional therapist, dietitian, and GP. Records were legible with name and designation of person making the entry identifiable.  Archived files are stored securely on site and are readily retrievable if required. No personal information was on display during the audit.
Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Specialist referral to the service was confirmed. Prospective residents and their families are encouraged to visit the facility. At this time, they are provided with an information pack and discussion around EPOA activation is held.  Family members confirmed they were satisfied with the information process and the information that had been made available to them on admission. Ten files reviewed contained complete demographic detail, assessments and signed admission agreements in accordance with contractual requirements. EPOA documentation was complete with activation letters sighted.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. At the time of transition between services appropriate information is provided including deescalating strategies for those with dementia, if required. A telephone handover is given to assist with smooth transitions. Documentation of a resident who recently went to the DHB confirmed that the family had been informed of the transfer.
Standard 1.3.12: Medicine Management  Consumers receive	FA	The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care. An electronic system is used at Brookhaven to provide a safe system of medication management. Staff observed demonstrated a clear understanding of their roles and knowledge of responsibilities related to each stage of medicine management. Senior care staff administer medication after

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>completing a medication competency that is renewed annually.</p> <p>Medications are supplied in blister packs from a contracted pharmacy. Senior staff check medications into the facility on arrival and they are stored in a locked medication trolley in the treatment room. Non packaged medicines are stored in a locked cupboard and stock rotated. All medications sighted were within current use by dates. Unused medications are stored in a locked cupboard for pick up by a contracted pharmacy.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register showed evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>Temperature records for the medication fridge and medication room were within accepted range.</p> <p>Prescribing practices showed requirements for pro re nata (PRN) medicines. Three monthly reviews were completed by the GP and recorded on the medication chart. The GP is able to access the electronic system so verbal orders are not used. There were two residents in the rest home who were self-administering medications at the time of audit. Assessments were completed and reviewed by the GP every three months. Residents were confident in the process and medications were stored in a safe manner. There have been five medication errors in the past six months which have been handled in an appropriate manner, including staff redoing medication competency, being supervised with medication rounds and a debrief with all staff to highlight the process.</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 at Brookhaven is provided on site by a team of qualified cooks and kitchen staff and was in line with recognised nutritional guidelines for older people. The menu rotates over summer and winter patterns using fresh produce delivered daily. A qualified dietitian has reviewed the menu and made recommendations that have been implemented. The menu was last reviewed in March 2020. Kitchen staff have completed relevant food handling certificates. Ministry for Primary Industries have approved the food safety plan which was current until 2 July 2021. All aspects of food procurement, production, preparation, storage, transportation, and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Changes to the menu are documented in the daily food diary.</p> <p>A nutritional profile is taken on admission and updated six monthly, or sooner if required. This includes allergies, likes/dislikes, modified texture requirements and these are accommodated in the daily meal plan. For those requiring modified textures the food is placed in silicone moulds that resemble the shape of the food before serving maintaining the residents' dignity. Residents have access to food and fluids to meet their nutritional needs at all times. Snacks were available for the residents in the dementia unit.</p> <p>Evidence of resident satisfaction with meals was confirmed through resident and family interviews, resident meeting minutes and satisfaction surveys. Observation of a meal time showed the residents received</p>

		<p>adequate time to eat their meals in an orderly and calm environment.</p> <p>The kitchen provides cakes for residents' birthdays, celebrations, and theme days run by the activities coordinator. There is an area where residents in the rest home can make a drink if they want.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The RN confirmed that NASC assessments have been accurate regarding level of care and entry to the facility has been appropriate. 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/family/whānau and GP. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is gathered within required timeframes using validated nursing assessments, such as mobility/falls risk, cognition/behaviour, pain (Abbey pain scale for those unable to verbalise), nutrition profile and current abilities. These are used to complete individualised and personalised care plans. A detailed activities profile is completed by the diversional therapist with interventions covering the 24-hour period including de-escalating tools and activities to occupy the resident. All interRAI assessments were current and completed within required time frames by four interRAI trained staff. Resident/family/whānau interviewed confirmed their involvement in the assessment process.</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 ten care plans reviewed reflected the support required by residents and outcomes of the integrated assessment process along with clinical information. The needs triggered during interRAI assessments were consistently evidenced within the care plans. Behaviour management plans including triggers and interventions for behaviours were observed. The RN confirmed that care staff were consulted about resident abilities and needs.</p> <p>Integrated documentation was evidenced with input from the GP, nursing notes, diversional therapist, physiotherapist, and podiatrist. Changes in care have been added to the care plan and were signed and dated, with this information passed on to care staff at changes of shift handover.</p>
<p>Standard 1.3.6: Service</p>	FA	<p>Documentation, observations, and interviews confirmed the care provided reflected residents' needs, goals</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>and the plan of care. Care plans were personalised to individual resident's needs, medical conditions and age appropriate as the unit caters for a range of ages. The GP interviewed expressed that medical intervention was appropriate, orders completed and that the level of care was exemplary. Care staff spoken to confirmed that changes in care were passed on and implemented.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by three trained diversional therapists holding the national Certificate in Diversional Therapy. One works in the rest home and two are spread over the two dementia units. Their hours are Monday to Friday and caregivers support the residents at the weekend.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful and age appropriate for the residents. The resident's activity needs are evaluated as part of the formal six monthly care plan review and in response to changing needs.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities that are age appropriate. Individual, group activities and regular outings are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme varied and interesting. The residents were observed actively participating in an exercise class on the day of audit.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes pampering sessions, walks, exercises, music and happy hour. The residents have the opportunity to sit in a sensory room for some quiet time if required. The facility has many scenery banners that are changed in accordance with seasons and special occasions to provide variety.</p> <p>Residents and family interviewed said that residents were kept occupied in meaningful activities.</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>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur six monthly alongside interRAI reassessment, or sooner if there is a significant change to a resident's condition. Where progress differs from expected outcomes then changes are initiated in the LTCP which are signed and dated. STCPs were sighted for weight loss management showing evidence of dietitian involvement, increase in weight monitoring, and intervention such as the use of nutritional supplements. These were reviewed and evaluated weekly and either signed off as resolved or transferred to the LTCP if it was an ongoing issue. Family/whānau interviewed confirmed they were included</p>

		in any changes and the evaluation process.
<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>	FA	<p>Residents receive support from other health and/or disability service providers when required. Referrals were sighted for weight loss and specialist wound care management. Family/whānau were kept updated on the process and any interventions. Any acute referrals are attended to immediately, such as transferring the resident to accident and emergency department in an ambulance if required.</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>	FA	<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. Chemical safety is identified in the various hazard registers.</p> <p>General waste and recycled cardboard are managed via an external contractor with weekly and two weekly collections respectively. Other recycling is managed using the local weekly council collection.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. Items included gloves, masks, face shields, goggles and plastic aprons for example. Additional infection prevention strategies have been implemented to help manage the Covid-19 outbreak.</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>	FA	<p>A current building warrant of fitness (expiry date 12 July 2021) was publicly displayed beside reception at the front entrance.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. These included monitoring via a range of checklists and updates on an annual maintenance schedule. Due to rest home dementia services being provided in two distinctly separate areas, these areas are secured with numerical key locks to ensure resident safety.</p> <p>The testing and tagging of electrical equipment, calibration of bio medical equipment and weighing scales and checks of the hoist, hospital beds, for example, were current as confirmed in documentation reviewed,</p>

		<p>interviews with maintenance personnel and observation of the environment. Similarly, hot water checks are undertaken monthly and records sighted demonstrated levels are safe.</p> <p>Both internal and external areas are safely maintained and were appropriate to the resident groups and settings. The maintenance person described the recording system in place to ensure the maintenance and gardening crew are aware of any repairs needed. Records viewed confirmed issues are addressed in a timely manner. Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned.</p> <p>The environment was hazard free and resident safety was promoted. Although parts of the facility are now older, the interior has been renovated and this process is ongoing. External areas have well established planting that offers shade, concrete paths are level and lawns and gardens well maintained. Residents and family members were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility with 92 available for resident use. All residents' rooms have an ensuite attached to them. 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>	<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 room to store mobility aids such as walking frames throughout the facility. There is one person who uses a wheelchair and to improve the available space their room was decluttered as far as the person permitted. None of the residents have mobility scooters, therefore storage of these is not an issue. Rooms are all the same size and on the smaller size, however staff and residents reported the adequacy of bedrooms for this resident group.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities and to dine in. There are two lounges in the rest home area and one in each of the dementia service areas of Sumner and Hillview. Activities are generally organised within these areas. Residents can access an additional quiet lounge in the Sumner wing. Four dining areas are spread throughout the facility. Furniture is appropriate to the setting and residents' needs with different configurations available according to residents' choices.</p> <p>There are three courtyard areas that enable residents with dementia to move in and out while they remain safe.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Personal laundry is undertaken on site in two separate laundry rooms, one opposite the other. Towels and bed linen are laundered off site by a contracted provider. The laundry staff person interviewed had been in the role for more than 20 years. This person demonstrated a sound knowledge of the laundry processes, dirty/clean flow, and handling of soiled linen. A relief person covers weekends. Family members and residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner; however, the resident/next of kin survey feedback suggested possibilities for improvement, which the manager and staff are reviewing.</p> <p>There is a small designated cleaning team who have received appropriate training. Two of these staff have undertaken the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. The cleaning staff person interviewed demonstrated good practices. Chemicals were stored in locked rooms and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. The staff confirmed they receive feedback and are required to follow up on any identified shortcomings. The chemical company monitors the equipment and supplies to ensure efficacy.</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>	FA	<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.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on 12 January 2011. A trial evacuation and fire training take place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being 7 July 2020. The orientation programme includes fire and security training and staff are required to attend updates, including a trial evacuation and gas safety training at least annually. Staff</p>

		<p>confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food and blankets meet the National Emergency Management Agency recommendations for the region. A ceiling water tank and multiple bottles of water are available and there are two barbecues, access to gas cooking facilities in the kitchen and a spit roast machine. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff are trained to call emergency services for any suspected breach of security. Windows have devices with restricted opening capacity. A gate has been installed on one edge of the property as it opens onto a busy road.</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. Each room has natural light filtering through external windows. There are glass doors from corridors and communal areas that open onto outside garden areas.</p> <p>Heating is provided by thermostatically controlled electric convection heaters in residents' rooms, fan heaters in the en-suites and heat pumps in communal areas. There is underfloor heating in the extension of one wing (Summer). Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. There is a designated outside smoking area.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to control and contain the risk of infection to residents, staff, and visitors. The programme is supported by a comprehensive and current infection control manual. The IPC programme is reviewed annually by the IPC coordinator and IPC clinical manager who oversees the organisation's sites. The programme was last reviewed 12 February 2020.</p> <p>A job description was sighted for the IPC coordinator. All infection control matters including surveillance are reported to the IPC clinical manager monthly and quality meetings.</p> <p>Under Covid-19 level 2 restrictions visitors are let into the facility and complete a Covid-19 checklist, have their temperature taken and use hand sanitiser. Masks are worn when physical distancing is not possible. Staff are aware if they are unwell, they must remain off work until symptom free for 48 hours.</p>
Standard 3.2: Implementing	FA	The IPC coordinator has appropriate skills and training to implement the programme and accesses additional

<p>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>support from the GP and DHB if needed. During Covid-19 restrictions, support was provided through the New Zealand Aged Care Association and the Ministry of Health.</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>The IPC policies are in line with good practice and meet legislative requirements. Review of policies occurred in February 2020 and the clinical manager stated they were reviewed annually. The policies and procedures are available in hard copy in each of the nurses' stations.</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>	<p>FA</p>	<p>IPC education has been increased due to Covid-19 with an emphasis on hand hygiene, donning and doffing personal protective equipment, pandemic response with both internal and external audits being performed. The staff interviewed were confident in understanding the requirements in place at this time.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and included infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, and upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these are documented. New infections and any required</p>

<p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>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. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager/quality and the IPC committee.</p> <p>A summary report for a recent respiratory infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The restraint coordinator is a registered nurse who has been in the role for approximately six years. It is this person's role to provide support, oversight and education in relation to enabler and restraint management in the facility. The restraint coordinator demonstrated a sound understanding of the organisation's related policies, procedures and practices and during a description of their responsibilities repeatedly mentioned the role of de-escalation and management and monitoring of challenging behaviours.</p> <p>During interview, staff were aware of the difference between types of restraint and the voluntary nature of an enabler. There were no restraints, or enablers, in use on the day of audit. Staff also reported during interview that they work in a restraint free environment, other than the securing of the doors for the safety of residents with dementia. Restraint is used as a last resort when all alternatives have been explored.</p> <p>One episode of physical restraint had been used in October 2019. The restraint coordinator reported that this was the only known use of a restraint in this facility in the six years that they have been in the role. Records relating to the episode were reviewed and demonstrated a full investigation and review process had occurred. Restraint approval group minutes reflected the follow-up actions taken and the clinical manager reported that an organisation-wide review of restraint processes followed. The person concerned had been new to the facility at the time of the event and appropriate monitoring and interventions were implemented afterwards to prevent a recurrence. No further use of restraint was required, and this person is now contributing to life in one of the dementia wings in a meaningful way by assisting staff and other residents with an ongoing activity programme.</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, 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.