

Oceania Care Company Limited - Franklin Rest Home

Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services 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:	Oceania Care Company Limited
Premises audited:	Franklin Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 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:	43

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Franklin Rest Home provides rest home, hospital and dementia levels of care for up to 44 residents. There were 43 residents residing at the facility on audit days.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the district health board.

The audit process included the review of policies and procedures, review of resident and staff files, and observations and interviews with residents, family members, management, staff, and a general practitioner.

There was one area identified as requiring improvement relating to corrective action plans.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process, and the Nationwide Health and Disability Advocacy Service is accessible. This information is brought to the attention of residents and their families on admission to the facility. Residents and family members confirmed their rights are being met, staff are respectful of their needs and communication is appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent is practised and written consent is gained when required. Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

There are policies and procedures about the management of complaints that align with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

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.		Some standards applicable to this service partially attained and of low risk.
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Oceania Healthcare Limited is the governing body and is responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned. There are systems in place for monitoring the services provided, including regular reports to the Oceania Healthcare Limited national support office.

The facility is managed by a business and care manager. A clinical leader is responsible for the oversight of the clinical services in the facility.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented and acted upon.

There are policies and procedures on human resource management and the processes are implemented. An orientation programme is provided to all new staff and staff participate in the mandatory education programme.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice.

Resident information is recorded in an accurate and timely manner. The privacy of resident information is maintained.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after admission.

The interRAI assessment is used to identify residents' needs; these are completed within the required timeframes. The general practitioner completes a medical assessment on admission and reviews occur thereafter on a regular basis.

Person centred care plans are developed using an electronic system and implemented within the required timeframes. These are individualised and based on an integrated range of clinical information. Residents' needs, goals and outcomes are identified. All residents' files reviewed demonstrated evaluations are completed six-monthly or earlier if there are changes in the resident's condition. Residents and their relatives are involved in the care planning process and are notified regarding any changes in a resident's health status.

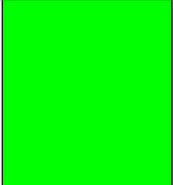
Short-term care plans are in place to manage short-term issues or problems as they arise. Handovers between shifts guide continuity of care and teamwork is encouraged.

An electronic medication management system is in place. Medication management is in line with the legislation and contractual requirements. Medications are administered by registered nurses and health care assistants who have completed current medication competency requirements.

The activity programme is managed by an activities coordinator and overseen by a diversional therapist from another Oceania Healthcare Limited facility. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The service uses its facility van for outings in the community. Family are able to participate in the activities programme.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control certificate. Kitchen staff have food safety qualifications.

Safe and appropriate environment

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

There is a reactive and preventative maintenance programme. This includes equipment and electrical checks.

Residents' bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids, and to allow for care to be provided. Lounges, dining areas, and sitting alcoves are available for residents and their visitors. External areas and gardens are available, accessible and appropriate.

A call bell system is available to allow residents to access help when needed. Security systems are in place with regular fire drills completed.

Protective equipment and clothing is provided and used by staff. Chemicals are safely stored. The laundry service is undertaken off-site. Cleaning of the facility is conducted by household staff and monitored.

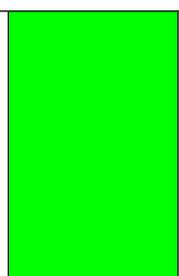
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse.

On the day of the on-site audit, two restraints and one enabler were in use. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary.

Infection prevention and control

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

The infection control nurse is responsible for the oversight and implementation of infection prevention and control at the facility. Infection control education is provided to staff at orientation and at ongoing education and training days.

Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Oceania Healthcare Limited national office.

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	49	0	1	0	0	0
Criteria	0	100	0	1	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>Policies, procedures and processes are in place to meet the facility's obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code. Staff were respectful of residents' rights as observed in their communications with residents and family members; encouraging residents' independence; and maintaining residents' dignity and privacy.</p> <p>Staff training on the Code is included in the staff orientation process and part of ongoing training.</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>The informed consent policy guides staff in relation to informed consent and staff interviewed understood the principles and practice of informed consent.</p> <p>The residents' computerised records evidenced documented consents using the organisation's standard consent form. This includes consent for photographs, outings, and collection and sharing of health information. Consent is also obtained on an as-required basis, such as for influenza vaccinations.</p> <p>There was evidence of advance directives signed by the residents, in all resident files sampled. Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was</p>

		<p>happening with their relative and consulted when treatment changes were being considered.</p> <p>Staff were observed gaining verbal consents for day to day care.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. Staff demonstrated understanding of the advocacy service, with contact details for the service readily available at the facility.</p> <p>Residents are provided with information on the advocacy service as part of the admission process and the availability of printed material about this service. Residents and family members confirmed their awareness of the advocacy service and how to access this.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>During COVID-19 pandemic the facility had implemented a new system for family to visit the facility. Visiting can occur 7 days a week between the hours of 10 am to 3 pm. Visitors are required to wear masks and visits take place in the residents' rooms. Interviews with family members confirmed this system is working well. Family members advised they feel welcome when they visit.</p> <p>The activities programme includes regular outings in the facility's mobility van. Community groups and entertainers also visit 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>Policies and procedures relating to complaints management are compliant with Right 10 of the Code. Systems are in place that ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. The complaints forms are displayed and accessible within the facility. Staff interviews confirmed their awareness of the complaints process. Residents and families demonstrated an understanding and awareness of these processes.</p> <p>The complaints management within the facility is the responsibility of the BCM. The review of the 2019 and 2020 complaints evidenced the required processes relating to Right 10 of the Code were followed. There have been no external investigations since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	FA	<p>During the admission process, new residents and their family are given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service (advocacy service). Posters on the Code are displayed in the facility. Pamphlets are available for residents, staff and family on the Code and the advocacy service.</p>

rights.		Residents and family members interviewed were familiar with the Code and the advocacy service. Residents and family stated they would feel comfortable raising issues with staff and management.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff communicated their knowledge about the need to maintain residents' privacy and were observed doing so throughout the audit.</p> <p>Residents' care plans include documentation relating to residents' abilities and strategies to maximise independence. Residents' computerised records confirmed that residents' individual cultural, religious, social needs, values, and beliefs were identified, documented, and incorporated into their care plan.</p> <p>The policy on abuse and neglect was understood by staff interviewed, including what to do should there be any signs of abuse or neglect. Education on abuse and neglect is part of the staff orientation programme and is included in the mandatory staff study days.</p> <p>The residents and their families confirmed they receive services in a manner that has regard for their dignity, privacy, spirituality, and choices.</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>The service has a Māori health plan that guides staff in meeting the needs of the residents who identify as Māori. Any additional cultural support, if required, would be accessed locally. This was confirmed at interview with the business and care manager (BCM). At the time of the audit there were three residents who identified as Māori. The review of their clinical records confirmed their individual cultural needs were being met.</p> <p>Family/whānau are able to visit their family members at the facility and are part of the care planning and evaluation care processes. Interviews with family confirmed they were informed of their family member's changes in condition when this occurred, are invited to residents' meetings, receive newsletters, and are involved in multidisciplinary team reviews.</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,</p>	FA	<p>The individual preferences, values and beliefs of residents were documented in the care plans reviewed. Residents and family members stated they had been consulted about residents' individual ethnic, cultural, spiritual values, and beliefs, and confirmed that these were respected.</p>

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>Residents and family members stated that residents were free from any type of discrimination or exploitation.</p> <p>Staff are guided by policies and procedures and communicated understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. Staff orientation includes information related to all forms of discrimination and exploitation, professional boundaries and expected behaviours.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The Oceania Healthcare Limited (Oceania) national office personnel provide support to the facility.</p> <p>The service encourages and promotes good practice through evidence-based policies and procedures, input from external specialist services and allied health professionals. For example: physiotherapists; and wound care specialists.</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>A review of accident/incident forms showed timely communication with residents and/or family members. Communication with family members is recorded in the residents' clinical records. The residents and family members stated they were kept informed about any changes to their own or their relative's status, and were advised about incidents or accidents and the outcomes of medical reviews. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the district health board (DHB) or interpreter services when required. There were no residents who required interpreting services on audit days, this was confirmed at management interviews.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Oceania is the governing body, with the executive management team providing support to the facility. The regional clinical and quality manager provided support to the facility during this audit. Monthly management reports provide the Oceania executive management team with progress against key quality indicators.</p> <p>Oceania mission statement, values and goals are communicated to residents, staff and family through information booklets and in staff orientation and training.</p> <p>The facility is managed by a BCM who is supported by a clinical leader (CL). The BCM has been</p>

		<p>employed by Oceania for 14 years in administrative roles and has been in the BCM position for 2 years.</p> <p>The clinical care at the facility is overseen by the CL, who is a registered (RN) and has been in this position for approximately six years. The CL previously worked with Oceania as an RN for four years. The management team is supported in their roles by the Oceania executive and regional teams.</p> <p>Franklin Rest Home (Franklin) is certified to provide rest home, hospital and dementia levels of care for 44 residents. There were 43 beds occupied at the time of the audit. Occupancy included 2 residents requiring rest home level care, 24 hospital level residents and 17 residents assessed as requiring dementia level of care. The service has contracts with the DHB for the provision of rest home, hospital, dementia and respite care services. There were no residents receiving care under the young people with disabilities (YPD) contract or respite care.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The service has appropriate systems in place to ensure continuity in the day-to-day operations should the BCM or the CL be absent. The CL, with support from the regional clinical and quality manager, stands in when the BCM is absent. When the CL is absent, a RN takes over the responsibilities of this role, confirmed at BCM interview.</p> <p>Oceania support office provides additional assistance when needed.</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>PA Low</p>	<p>Franklin uses the Oceania quality and risk management framework. The policies and procedures guide service delivery at the facility. The policies are reviewed bi-annually and are linked to the Health and Disability Sector Standards, current and applicable legislation and evidenced based best practice guidelines. New and revised policies are presented to staff to read, and staff sign to confirm they have read and understood the policy.</p> <p>Monthly and bi-monthly meetings include: staff meetings; quality meetings; health and safety; RN; infection control and restraint meetings. There was evidence that corrective actions from some meetings are not consistently addressed.</p> <p>Service delivery is monitored through review of: complaints; incidents and accidents; surveillance of infections; pressure injury and soft tissue/wound reviews; and implementation of an internal audit programme.</p> <p>Review of the quality improvement data provided evidenced that the data is being collected, collated, evaluated, and analysed to identify trends. The data is reported to staff and to the national</p>

		<p>support office. Internal audit schedules and completed audits were reviewed and evidenced corrective action plans were documented when required.</p> <p>The health and safety annual plan identifies lists of tasks to ensure safe place of work and adhering to legal requirements. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risks, these are reviewed annually.</p> <p>Resident/family satisfaction surveys are completed six-monthly and results confirmed residents' satisfaction with the levels of care they receive. Results of the satisfaction survey were communicated to the residents and the family via the facility newsletter.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The management staff are aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police investigations, sentinel events, infectious disease outbreaks and changes in key management roles. The Oceania sentinel report and the HealthCERT Section 31 report, for reporting a facility acquired pressure injury, was evidenced.</p> <p>Adverse, unplanned or untoward events are recorded on an accident/incident form and on the computerised management system. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events, which are reviewed and signed off by the BCM and the CL.</p> <p>Accident/incident reports reviewed had corresponding corrective action plans. There is evidence of open disclosure for recorded events. Staff inform families after adverse events, as confirmed in clinical records and during family and resident interviews.</p> <p>Adverse event information is shared at facility meetings. Adverse events are graphed, trends analysed, benchmarking of data is occurring and compared with other Oceania facilities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The service has implemented policies and procedures in relation to human resource management.</p> <p>The skills and knowledge required for each position is documented in job descriptions. Review of staff files evidenced: employment agreements; reference checks; criminal vetting; drug testing; and completed orientation and competencies. Current copies of annual practising certificates were sighted for staff and contractors that require them to practise. An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.</p> <p>The organisation has an annual training and education programme which includes mandatory staff education and training. Staff complete in-service training around a variety of clinical topics. An</p>

		<p>orientation/induction programme is available and new staff are required to demonstrate competency on a number of tasks, including but not limited to, personal care and emergency and security systems. Health care assistants (HCA) confirmed their role in supporting and buddying new staff. Individual staff attendance records were reviewed and evidenced that ongoing education is provided. Staff who work in the dementia unit have completed dementia training.</p> <p>Four out of five RNs have completed interRAI assessment training and competencies. Annual competencies are completed by care staff, for example: hoist; oxygen use; hand washing; wound management; infection control; medication management; moving and handling; and restraint. Education and training hours for each staff member are at least eight hours a year. The RNs' training records reviewed evidenced eight hours or more of relevant training.</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>	FA	<p>The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents.</p> <p>Rosters reviewed showed that staffing levels meet resident acuity and bed occupancy. There is use of bureau staff when required. On call is provided by the CL after hours. There are Oceania processes in place to manage staffing during a pandemic and staff and management are aware of these.</p> <p>There are 49 staff including: clinical staff; activities coordinator; maintenance person; kitchen and housekeeping staff. There is a RN on duty on each shift. Care staff interviewed reported adequate staff are available and that they can get through their work. Residents and families confirmed staffing is adequate to meet the residents' needs.</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>	FA	<p>There are policies and procedures in place for privacy and confidentiality of residents' records. The service retains relevant and appropriate information to identify residents and track residents' records, including information collected on admission with the involvement of the family.</p> <p>Staff interviews confirmed they are familiar with the electronic record management system. The computerised clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals in the system. Both residents' records, clinical and medication charts are in an electronic format. All records are accessible by authorised personnel only.</p> <p>Resident care and support information can be accessed in a timely manner. Documents containing sensitive resident information are not displayed in a way that could be viewed by other residents or</p>

		<p>members of the public.</p> <p>Archived records are securely stored and easily retrievable at the facility.</p> <p>Residents' progress notes are completed on every shift, detailing resident response to service provision and progress towards identified goals and entered onto the computerised system.</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>	FA	<p>Needs Assessment and Service Coordination (NASC) assessments are completed for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. There is a comprehensive information pack provided to all residents and their families prior to admission. Prospective residents and/or their families are encouraged where possible to visit the facility prior to admission. Review of residents' files confirmed implemented entry to service processes, ensuring compliance with entry criteria. Interviews with residents and family, and review of records confirmed the admission process was completed in a timely manner. Residents and family members interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and coordinated manner. The service uses DHB documentation in addition to the services transfer documents, to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</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>A current medication management policy identifies all aspects of medicine management in line with the current legislation and guidelines.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices in line with legislation, protocols and guidelines were observed. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities are documented on the electronic medication chart.</p> <p>The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for</p>

		<p>returning expired or unwanted medication to the contracted pharmacy.</p> <p>Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN confirmed this. The medication refrigerator temperatures are monitored weekly.</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks and six-monthly stocktakes of medications are conducted in line with policy and legislation.</p> <p>The staff observed administering medication demonstrated knowledge of the medication administration process and complied with the medicine administration policies and procedures. In interview they demonstrated clear understanding of their roles and responsibilities relating to each stage of medication management The RNs oversee the use of all pro re nata (PRN) medicines and documentation made regarding effectiveness on the electronic medication record and in the progress notes, which were sighted. Current medication competencies were evident in staff files.</p> <p>There was one resident self-administering medication during the on-site audit. A process is in place to ensure ongoing competency of the resident and self-medication is authorised by the GP. Verification of self-administration of medication by the RN occurs and is documented. Safe storage for medication is provided.</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>All meals are prepared on site and served in the dining rooms or in the resident rooms if requested. The seasonal menu has been reviewed by a dietitian, with the winter menu implemented at the time of audit. The food control plan is current and expires in March 2021. Food management training and certificates for cooks and kitchen staff were sighted.</p> <p>Food temperatures are monitored appropriately and recorded. The kitchen staff have relevant food hygiene and infection control training. The kitchen was observed to be clean and the cleaning schedules sighted.</p> <p>A nutritional assessment is undertaken for each resident on admission by the RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident's dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning.</p> <p>Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. There were sufficient staff to ensure appropriate assistance was available.</p>

		<p>Residents and families interviewed stated that they were satisfied with the meals provided.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and cool store. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated.</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 service has a process in place if access is declined. When residents are declined access to the service, residents and their family/whānau, the referring agency and general practitioner (GP) are informed of the decline to entry. The resident would be declined entry if not within the scope of the service or if a bed is not available. A waiting list is maintained.</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>The initial nursing assessment and the initial care plan are completed within 24 hours of admission. The initial care plan guides care for the first three weeks. RNs complete the interRAI assessment within the required timeframes. The PCCP is based on the interRAI assessment outcomes. Assessments are recorded, reflecting data from a range of sources, including: the resident; family/whānau; the GP and specialists.</p> <p>Policies and protocols are in place to ensure continuity of service delivery. Assessment tools are reviewed at least six-monthly, including mobility, dietary, oral and dental, pressure injury and continence. Additional assessments were completed according to need, for example wound assessments and behaviour assessments. The outcomes of all assessments, needs and supports required, were reflected in the care plans.</p> <p>Interviews with residents and families confirmed their involvement in the assessment, care planning, review, treatment, and evaluation of care.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and</p>	FA	<p>Person-centred care plans are developed with the resident and family/whānau involvement. All residents' files sampled had an individualised long-term care plan. Person centred care plans describe interventions in sufficient detail to meet residents' assessed needs. Short-term care plans are developed for the management of acute problems.</p>

<p>promote continuity of service delivery.</p>		<p>Person centred care plans were amended to reflect changes in health status and were reviewed on a regular basis. Care plans included the involvement of allied health professionals in the care of residents for example physiotherapy input and interventions.</p> <p>Resident files are managed using an electronic system. Resident files showed service integration with clinical records, activities notes, medical and allied health professionals' reports and letters. Interviews with residents confirmed that they have input into their care planning and review, and that the care provided meets their needs.</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>Person centred care plans are completed by the RN and based on the assessed needs, desired outcomes and goals of residents. Interventions are reviewed within required timeframes. The GP documentation and records reviewed were current. Interviews with residents and families confirmed that care and treatment met residents' needs. Staff interviews confirmed they are familiar with the needs of residents in the facility. Family communication is recorded in the progress notes. The nursing progress notes and observations are recorded and maintained.</p> <p>The GP interviewed visits the facility once a week. They verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard.</p> <p>Monthly observations such as weight and blood pressure are completed and are up to date.</p> <p>Wound assessments, treatment and evaluations were in place (on the electronic database) for thirteen wounds which included five pressure injuries: one unstageable; three stage two and one stage one. A section 31 had been completed for the unstageable pressure injury. In files reviewed all residents had a pressure injury risk assessment in place and interventions were documented for those residents identified as at risk of developing pressure injuries. There was evidence of referral to the DHB wound clinical nurse specialist and pressure relieving equipment was available. Pressure injuries were reported through the Oceania quality and risk management programme.</p> <p>Scheduled change of dressings and evaluations had been completed. Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe access to the DHB wound clinical nurse specialist as required. Continence products are available and resident files included urinary continence assessment, bowel management and continence products identified for day use, night use and other management.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	<p>FA</p>	<p>The residents' activities programme is implemented by an activities coordinator and overseen by a diversional therapist (DT) from another Oceania facility. Activities for the residents are provided 5 days a week, Monday to Friday 8:30 am to 5:00 pm by the activities coordinator. On weekends a</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>range of activities are made available for residents, staff and family to access. Activities are provided in the morning (8:30 am-12:30 pm) in the rest home and hospital, and in the afternoon (1:00 pm – 5:00 pm) in the dementia unit. The activities programme is displayed on the resident noticeboards. The programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural, spiritual and community events. Church services are held weekly. Van outings into the community are arranged weekly for the residents living in the rest home and hospital and in the dementia unit.</p> <p>The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on the residents' interests, family and previous occupations is gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed six-monthly at the same time the care plans are reviewed and are part of the formal six-monthly multidisciplinary review process.</p> <p>All residents living in the secure dementia wing have a behaviour assessment on admission. Behaviour management plans for dementia care residents over the 24-hour period included de-escalation and redirection through the use of individual one-on-one time and activities. Health care assistants in the dementia care unit incorporate activities and one-on-one time with residents as part of their role.</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 at handover and in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Person centred care plans are evaluated every six months in conjunction with the interRAI re-assessments or if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes.</p> <p>The multidisciplinary review involves the CL, RN, and activities staff. Input is sought from HCAs and other allied health professionals involved in the care of the resident. The GP reviews the residents at least three-monthly. Family are notified of the outcome/changes if unable to attend.</p> <p>Residents and families interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident's records and documented in the individual resident files reviewed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Where needed, referrals are sent to ensure other health services, including specialist care is provided for the resident.</p>

<p>(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>Referral forms and documentation are maintained on resident files. Referrals are regularly followed up. Communication records reviewed in the residents' files, confirmed family/whānau are kept informed of the referral process.</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.</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>Oceania policies and procedures provide guidelines for staff in the management of waste and hazardous substances.</p> <p>The hazard register is current. Material safety data sheets are available and accessible for staff.</p> <p>Staff receive training and education in safe and appropriate handling of waste and hazardous substances. There are two sluice rooms at the facility. Staff were observed using personal protective equipment (PPE) and clothing when this was required.</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>The service has a current building warrant of fitness displayed. There have been no building modifications since the last audit.</p> <p>Interview with the maintenance person confirmed there is a planned and reactive maintenance schedule in place. Monthly building inspections are completed by the provider and by an external contractor.</p> <p>The medical and electrical equipment had been checked for safety and performance verification in accordance with relevant standards. Annual service reports and equipment labels denoting that the equipment has passed performance verification tests were sighted.</p> <p>Interviews with staff and observation of the facility confirmed there is adequate equipment.</p> <p>The service provides mobility access throughout the facility. There are quiet areas at the facility for residents and their visitors to meet. There is access to an internal courtyard and external garden areas with outdoor furniture and shade for rest home and hospital residents. The dementia unit has a secure outdoor area that has been upgraded and provides safe environment for outdoor activities for the residents with dementia.</p> <p>Monthly hot water temperature testing evidenced temperatures were within safe levels.</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>Toilets are accessible close to the communal areas. Separate toilets are provided for visitors and staff. All the toilets have a system that indicates if it is engaged or vacant.</p> <p>The bathroom facilities are of an appropriate design to meet the needs of the residents. Residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence.</p> <p>The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Residents and family members reported that there are sufficient toilets and showers. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.</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>There are 26 dual purpose residents' rooms within the facility. There is adequate space for resident, staff and mobility equipment in the room at any time.</p> <p>Residents' rooms are individualised with residents' own furnishings, photos and other personal possessions. Residents and families are encouraged to make the room their own.</p> <p>All residents' rooms are of single accommodation, with hand washing facilities.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is one lounge and dining area to accommodate rest home and hospital residents. A separate lounge and dining area is located in the dementia unit. All communal areas are easily accessed by residents and staff. Residents and family members can access areas for privacy, when required.</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>The laundry service is completed off-site. There are processes in place for daily collection, transportation and delivery of linen. Residents' laundry is sorted and delivered to their rooms.</p> <p>The effectiveness of the cleaning and the laundry services are audited as part of the internal audit programme. There are cleaners on site during the day, seven days a week. There are safe and secure storage areas for chemicals and cleaning products. The chemicals are administered through a closed system which is managed by a chemical contractor company. The cleaners have specific guidelines to ensure appropriate cleaning processes are completed. The cleaner interviewed confirmed cleaning processes are in place and chemical safety training has occurred.</p>

		<p>Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility.</p> <p>Residents and families stated they were satisfied with the cleaning and the laundry services.</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>The service has documented systems in place for essential, emergency and security services.</p> <p>Staff who drive the van to transport residents, are required to complete first aid training. There is at least one designated staff member with first aid training on each shift. Emergency and security management education is provided at staff orientation and at the mandatory in-service education programme. Staff records provided evidence of current training relating to fire, emergency and security.</p> <p>There is a system in place for security to ensure all entrances are locked after dark. Visitors and contractors are required to sign in and out of visitors' registers, as observed on audit.</p> <p>The service has a fire evacuation scheme which has been approved by the New Zealand Fire Service and dated 5 October 2005. Information in relation to emergency and security situations is readily available/displayed for staff, residents and visitors. Fire evacuation trials are completed six-monthly, and were last conducted in May 2020.</p> <p>Emergency equipment is accessible, current and stored appropriately with evidence of emergency lighting, torches, gas and barbeque for cooking, extra food supplies, emergency water and blankets.</p> <p>The service has a call bell system in place, which includes an escalation system if an activated call is not answered within a specified timeframe. Unanswered call bells are escalated to the RN; CL; the BCM; and the clinical and quality manager, if not answered promptly. All residents have access to a call bell. Call bells are checked monthly by the maintenance person. Residents confirmed staff respond to call bells in a timely manner.</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</p>	FA	<p>Policies and procedures are in place to ensure the service is responsive to residents' feedback in relation to heating and ventilation. Residents are provided with adequate natural light, safe ventilation and heating. There are electrical heaters and heat pumps throughout the facility, which are able to be temperature controlled.</p> <p>Families and residents confirmed that rooms are maintained at an appropriate temperature. There is a specific area designated for staff and residents that smoke.</p>

temperature.		
<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>Franklin provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. The CL is the infection control nurse (ICN) and has access to external specialist advice from the DHB ICN. A documented job description for the ICN, including role and responsibilities, is in place.</p> <p>The infection control programme is appropriate for the size and complexity of the service. The infection prevention and control programme is reviewed annually. Staff are made aware of new infections through daily handovers on each shift, progress notes and clinical records. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN is responsible for implementing the infection control programme. There is an infection control committee which is made up of staff members from each work area. The committee meets monthly. The ICN has attended training for the role.</p> <p>The ICN stated that there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's quality meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</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>Oceania has documented policies and procedures in place that reflect current best practice relating to infection prevention and control.</p> <p>Staff were observed complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions. They were able to locate policies and procedures.</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>All staff attend infection prevention and control training. Staff education on infection prevention and control is provided by the ICN at orientation and for HCAs at the annual study days. Recently staff have attended training in donning and doffing of PPE and hand washing. Records of attendance are maintained. Staff interviewed confirmed that education on infection prevention and control is provided.</p> <p>Education with residents, when possible, is generally on a one-to-one basis and includes reminders about handwashing and remaining in their room if they are unwell. Recently education has been provided at the residents' meetings about the importance of handwashing. Staff provide education for residents where appropriate about COVID-19 as updates occur. There is information regarding infection prevention and COVID-19 displayed on the noticeboards. Staff receive notifications and updates about infection control via meetings and at handovers. Family are kept informed by a newsletter and emails regarding visiting restrictions and COVID-19 updates.</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>Oceania surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed.</p> <p>Short-term care plans are developed to guide care and evaluate treatment for all residents who have an infection. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. Families are updated by phone, email or text if required.</p> <p>Surveillance data is collected and collated monthly by the CL and forwarded to the Oceania national office for benchmarking using an electronic system. Information following monthly infection data collection and benchmarking is provided to staff through quality and staff meetings.</p> <p>Interview with the ICN confirmed there have been no outbreaks since the previous audit.</p> <p>COVID-19 information is available to all visitors to the facility. Oceania information including Ministry of Health information was available on site. Stocktakes of PPE occur weekly to ensure that there are adequate infection prevention and control resources available should a resident infection or outbreak occur. There are designated areas for donning and doffing of PPE throughout the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the CL and they provide support and oversight for enabler and restraint management in the facility. The restraint coordinator is conversant with restraint policies and procedures.</p>

		<p>On the day of the audit, two residents were using restraints. One resident was using bedrails and another was using a chair brief. One resident was using bedrails as an enabler 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 any restraint use.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of restraint minimisation. Regular training occurs. Review of restraint and enabler use is completed and discussed at all quality and clinical meetings.</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 process is described in the restraint minimisation policy. The restraint coordinator is the CL with a job description that defines the role and responsibility of the restraint coordinator.</p> <p>An assessment and management process is followed for the use of both restraints and enablers which ensures the ongoing safety and wellbeing of residents. This includes cultural considerations. The restraint coordinator explained the process for determining approval, for recording, monitoring and evaluating any restraints or enablers used. Family/whanau approval is gained should any resident be unable to do so and any impact on family is also considered. This was evidenced by documentation and files viewed.</p> <p>Training for staff occurs at orientation and in the annual study days for HCAs and at the RN training days. The restraint coordinator also requires all staff to complete a competency quiz annually.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint/enabler policy details the process for assessment. Assessment covers the need, alternatives attempted, risk, cultural needs, impact on the family, any relevant life events, any advance directives, expected outcomes and when the restraint will end. Completed assessment templates were sighted evidencing assessment, including consultation with family.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Restraint and enablers are only used to maintain resident safety and only as a last resort. The restraint coordinator discusses alternatives with the resident, family/whanau and staff for example low beds and sensor mats.</p> <p>Once approved and in use, the restraint is closely monitored and documented. Documentation includes the method approved, when it should be applied, frequency of checks and when it should end. It also details the date, time of application and removal, risk/safety checks, food/fluid intake,</p>

		<p>pressure area care, toileting, and social interaction during the process.</p> <p>Internal audits conducted measure staff compliance in following restraint procedures. A restraint register is maintained, and updated monthly and reviewed by the restraint coordinator who shares the information with staff at the monthly quality and clinical meetings.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>All restraints are reviewed and evaluated as per Oceania policy and requirements of the standard. Use of restraints and enablers is evaluated two-monthly or more often according to identified risk. The evaluation includes a review of the process and documentation, including the resident's care plan and risk assessments, future options to eliminate use and the impact and outcomes achieved.</p> <p>One restraint has been discontinued recently following evaluation and discussion with GP and family.</p> <p>Family/whanau are included in the evaluation process. Evaluations are discussed at the monthly quality and clinical meetings.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>A review of documentation and interview with the CL demonstrated the monitoring and quality review of the use of restraints.</p> <p>The internal audit schedule was reviewed and included review of restraint minimisation reviews. The content of the internal audits included the effectiveness of restraints, staff compliance, safety and cultural considerations.</p> <p>Staff monitor restraint related adverse events while restraint is in use. Any changes to policies, guidelines or education are implemented if indicated. Data reviewed, minutes and interviews with staff including care staff and RNs confirmed that the use of restraint has reduced and is only used as a last resort.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>There are regular meetings at the facility occurring and minutes of these meetings are maintained.</p> <p>Meeting minutes do not consistently identify areas requiring improvement. The corrective action process is not always documented identifying the required changes; the persons responsible for the implementation of the corrective actions; timeframes for implementation and the sign off that this has occurred.</p>	<p>Corrective action plans arising from meetings are not consistently documented, implemented and signed off when completed.</p>	<p>Provide evidence that corrective action plans arising from meetings are documented, implemented and signed off when completed.</p> <p>180 days</p>

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.