

Taslin NZ Limited - Otatara Heights Residential Care

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 BSI Group New Zealand Ltd, 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:	Taslin NZ Limited
Premises audited:	Otatara Heights Residential Care
Services audited:	Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services - Psychiatric
Dates of audit:	Start date: 16 September 2020 End date: 17 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:	40

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

Otatara Heights Residential Care provides rest home, residential disability-physical and psychiatric level care for up to 40 residents. On the day of the audit there were 40 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures; the review of residents and staff files; observations; and interviews with residents, family, management, staff, and a general practitioner.

The service is managed by the owner/manager and a clinical nurse manager (registered nurse).

Improvements are required to activities, documentation by registered nurses and documentation of neurological observations.

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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Staff at Otatara Heights Residential Care ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussion with family members identified that they are fully informed of changes in their family member's health status. Communication with families is recorded. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Complaints processes are implemented and managed in line with the Code. Staff receive education on discrimination, and the services utilisation of the strengths and community participation model that ensures care is individualised and based on clients' values and strengths. Clients and family confirm staff communicate effectively and they are encouraged to maintain links with family/whānau along with access to community services which is supported and facilitated by staff.

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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Otatara Heights Residential Care is implementing a quality and risk management system that supports the provision of clinical care. Quality management processes are reflected in the businesses plans, goals, objectives, and policies. Quality data is collated and discussed at staff, management, and operation/H&S meetings. There is a current governance and quality plan in place. Staff document incidents and accidents. There are human resources policies including recruitment, job descriptions, selection and orientation. The service has an orientation programme that provides new staff with relevant information for safe work practice. The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

There is a client participation policy and processes in place and evidence of input at all levels. Clients are involved in planning, service improvements, training, and recruitment of staff. Clients were aware of how to have regular input into the service. Family said they could visit services at convenient times and were made welcome.

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.		Some standards applicable to this service partially attained and of low risk.
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The clinical nurse manager provides clinical oversight. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities coordinator provides support for residents to engage in activities with a focus on community participation. There are regular outings. Clients confirm they engage in activities that are meaningful to them and that reflect their priorities, interests, strengths, and skills. Staff interviewed were aware of clients' individual interests and strengths.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Snacks are available at all times.

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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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There is a main lounge that provides spaces for reading, games, and television. External areas are safe and well maintained with shade and seating available. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. There are sound processes and systems in place to manage dirty and clean laundry. Documented systems are in place for essential, emergency and security services.

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 to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort and for safety reasons. Staff receive regular education and training around management of challenging behaviour. There was one restraint (bedrail) used on the day of audit and no enablers in use.

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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks. Covid-19 guidelines are in place.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	3	0	0	0
Criteria	0	121	0	3	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 and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with ten staff (two registered nurses (RN), four healthcare assistants (HCA), one activities coordinator, one human resources administrator, one maintenance person and one cook) confirmed their familiarity with the Code. Six rest home residents (including one YPD and one ACC), three mental health residents and one ACC rest home respite resident and two family members (one ACC and one mental health resident) interviewed confirmed the services being provided are in line with the Code. Staff have completed annual training on the Code.</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</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on seven resident files reviewed (three rest home including one young person with a disability; one residential disability services – psychiatric; one long term services – chronic health condition; one ACC respite; one residential disability services – physical). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. The service has a resuscitative and advanced directive policy that includes definitions. The policy states that copies of the Enduring Power of Attorney (EPOA) documentation will be kept on</p>

informed consent.		the resident record. These forms are filed in the resident's file and referred to as necessary. All resident records reviewed (apart from the resident using respite services) had an EPOA on record.
<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	Rights to access advocacy services and independent advocates is identified for residents. Advocacy leaflets are available in the facility foyer area. The information pack provided to residents prior to entry includes advocacy information. The information identifies who the resident can contact to access advocacy services. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members that were interviewed were aware of their access to advocacy services.
<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	Residents and family members interviewed confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility. All residents, especially younger residents are provided with opportunities to engage in the community and younger residents are encouraged in these activities as they are able.
<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	The complaints policy and procedures have been implemented and residents and their family/whānau are provided with information on admission. The residents and family members interviewed were aware of the complaints process and to whom they should direct complaints. Complaint forms are visible at the entrance of the facility. A complaints register is maintained. There have been two complaints received in 2020 year to date and three complaints made in 2019 since the last audit. The documentation for the complaints reviewed showed investigation and actions taken, and that the complainants have been informed of the outcome/result.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The Code and advocacy pamphlets are located at the main entrance of the service. On admission the owner/manager or clinical nurse manager discusses the information pack with the resident and the family/whānau. This includes the Code, complaints, and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and family members interviewed identified they are well informed about the Code.

<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 interviewed were able to describe the procedures for maintaining confidentiality of resident records, residents' privacy, and dignity. House rules are signed by staff at commencement of employment. Residents and family interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy in place and staff have completed annual training on abuse and neglect. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious, and spiritual identity.</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 guidelines for the provision of culturally safe services for Māori residents. On the day of the audit there were nine residents that identified as Māori. The files of two residents that identified as Māori were reviewed and included a Māori health plan. The service has established links with local Māori community members (Kaumātua group with Te Taiwhenua O Heretaunga) who provides advice and guidance on cultural matters. Staff interviewed confirmed they are aware of the need to respond appropriately to maintain cultural safety.</p>
<p>Standard 1.1.5: Recognition Of Pacific Values And Beliefs</p> <p>Pacific consumers 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 cultural policy that recognises ethnicity, sexuality, gender, and individual beliefs and includes people who identify as Pacific. The policy links with local Pacific organisations. Pacific cultural needs are identified in the information at referral and the staff regularly review cultural needs with residents. Clients interviewed said their cultural needs are met. The family/whānau policy includes the importance of connection and involvement of family in the recovery journey. Staff interviewed understand and respect the cultural preferences of people of identify as Pacific. At the time of the audit there were no residents that identified as Pacific living at the facility.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Care planning and activities goal setting includes consideration of spiritual, psychological, and social needs. Residents and the family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. The family members reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>

<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy, and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries. The managers encourage open communication between staff, family/whānau and residents to promote early identification of any concerns.</p> <p>The organisation has a policy on the prevention of abuse and neglect and has policies and protocols in place on ethical principles and standards, code of ethics guidelines, code of rights and boundaries. Training on abuse and neglect and the Code is recorded in staff files and occurs regularly. Staff attend training to identify and prevent harassment and bullying. Management provide support for people who experience bullying or harassment.</p> <p>Senior staff follow-up complaints or allegations identified as causing concern. All staff interviewed had a clear understanding of the importance of professional boundaries and the impact of discrimination. Residents and family/whānau interviewed say they can choose to participate in activities or programmes without this affecting the support provided. The managers state that the service does not withdraw support or deny access to treatment and support programmes when or if the resident refuses some aspects of treatment. This was confirmed by residents interviewed.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The organisation has developed and implemented policies, procedures, and service delivery and clinical processes and systems that ensure there is a quality of service provided. All residents and family /whanau interviewed praised the staff for the difference the service makes to their life.</p> <p>The quality, safety and improvement programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. Three monthly staff and monthly management, operation/health and safety and residents' meetings are conducted. Staff interviewed stated that they feel supported by the owner/manager and clinical nurse manager. Residents and family members interviewed spoke positively about the care and support provided.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Residents and family members interviewed confirmed that the owner/manager, clinical nurse manager and staff are approachable and available. Twelve incident forms reviewed for August 2020 identified family were notified following a resident incident. The family members interviewed confirmed they are notified of any incidents/accidents.</p>

communication.		Families are invited to attend the monthly resident meeting. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, then interpreter services are made available.
<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>Otatara Heights Residential Care is owned by Taslin NZ Limited. The service is certified to provide rest home, residential psychiatric and physical level care for up to 40 residents. The service holds contracts with Hawke's Bay District Health Board (HBDHB), ACC and Ministry of Health disability support services.</p> <p>At the time of the audit there were 40 residents. There were 15 residents under Residential disability-physical level care including seven residents on young persons with disability (YPD) contracts, seven residents funded by ACC and one resident was on respite. There were nine residents under Residential disability- psychiatric on mental health contracts. There were 16 rest home residents including two residents on a long-term support chronic health conditions (LTS-CHC) contract, and 14 residents under the age-related residential care (ARRC) contract.</p> <p>The governance and quality plan 2019/2021, which is reviewed annually, outlines the purpose, values, scope, philosophy, direction, and goals of the organisation. The documents described annual and long-term objectives and the associated operational plans. A sample of the report to the management group showed adequate information to monitor performance is reported, including financial performance, quality data, staffing, emerging risks, and issues. A full governance review, which includes all managers and both owners, is undertaken on a regular basis with the last one being held in January 2020.</p> <p>The service is managed by an owner/manager who has owned the business for 7 years and has worked in aged care for 20 years. She is supported by a clinical nurse manager who has been in the role since June 2017. The clinical nurse manager has a current nursing annual practising certificate, a post graduate qualification in aged care and has worked in aged care for over 23 years. The owner/manager and clinical nurse manager are also supported by an administration manager and administrator/HR who has been in their roles for three years and one year. The owner/manager and clinical nurse manager confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through regular ongoing education related to the roles they have undertaken. The owner/manager had experience in dealing with mental health residents and younger people in her previous clinical manager roles.</p> <p>The manager/owner and clinical nurse manager have completed in excess of eight hours of professional development in the past 12 months.</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 owner/manager reported that in the event of her temporary absence the clinical nurse manager fills the role with support from the care staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Resident/family meetings occur every month. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management, operation/H&S, and staff meetings. Staff interviewed reported their involvement in quality and risk management activities through audit activities, and implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Resident and family satisfaction surveys are completed annually. The resident and family/friend satisfaction surveys were undertaken in July and August 2020, respectively. Both surveys were still being collated by the administration manager at the time of audit. Two young persons interviewed confirmed their satisfaction with their input into decision making related to their care and overall environment. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. Some policies were under review at the time of audit. The service has a health and safety plan in place that is regularly reviewed. Health and safety goals are established and regularly reviewed at the monthly operation/H&S meeting. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the</p>	<p>PA Low</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Twelve accident/incident forms were reviewed. The accident/incident forms reviewed documented timely RN review and follow-up; however, neurological observations were not completed for six unwitnessed falls with a potential head injury. There is documented evidence the family had been notified of incidents/accidents. Discussions with the owner/manager confirmed an awareness of the requirement</p>

<p>service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>to notify relevant authorities in relation to essential notifications including section 31 notifications. There have been no section 31 notifications lodged since the last audit.</p>
<p>Standard 1.2.5: Consumer Participation</p> <p>Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.</p>	<p>FA</p>	<p>The service has a policy and procedure for the participation of residents at all levels of the organisation. There is focus on recruiting employees who have with lived experience of mental distress and/or disability or family/whānau experience.</p> <p>An annual relative and resident satisfaction survey is completed and there are regular relative/resident meetings. Family/whānau members who have enduring power of attorney, on behalf of the resident have input into the service through satisfaction surveys, regular family meetings and informal feedback. The admission agreement also encourages residents to ask questions about their care plan. The Code of Health and Disability Services Consumer Rights (The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and resident-centred care planning training is provided to staff. Training also includes listening to experiences of people with disability or mental health issues.</p> <p>Managers pride the service on providing a family run home that is inclusive and flexible to the needs of the many different types of care requested. There are no paid groups or individuals to provide input into the service as the service supports and encourages all to have input into service delivery. Residents interviewed confirmed that this occurs.</p>
<p>Standard 1.2.6: Family/Whānau Participation</p> <p>Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.</p>	<p>FA</p>	<p>Family/whānau input occurs at both formal and informal levels. A family member for one of the mental health residents reported feeling included, valued and that feedback, and ideas listened to, and acted on. All family interviewed reiterated the 'family feel' of the service and all felt they were encouraged to have input into service delivery.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. This includes that the recruitment and staff selection process require that relevant checks be completed to validate the individual's qualifications, experience, and veracity. A copy of practising certificates is kept. Seven staff files were reviewed (one clinical nurse manager, one RN, three HCAs, one diversional therapist and one head chef) and there was evidence that reference checks were completed before employment was offered.</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>All files include documentation that reflected good employment processes. Annual staff appraisals were evident in all staff files reviewed. Completed orientation is on files and staff described the orientation programme. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>The in-service education programme for 2019 has been completed and the plan for 2020 is being implemented. The owner/manager, clinical nurse manager and RNs are able to attend external training, including sessions provided by Hawkes Bay DHB. Discussions with the HCAs and the RNs confirmed that ongoing training is encouraged and supported by the service. There are 22 HCAs in total with eight having completed level 4, eight have completed level 3 and two have completed level 2 NZQA National Certificate. There are four RNs, and one has completed interRAI training. The HCAs complete competencies relevant to their role such as medication competencies. Staff training has included sessions on privacy/dignity and spirituality/counselling to ensure the needs of younger residents are met. There is also training around management of challenging behaviour, community participation and supporting residents to live full lives. Mental health training included, de-escalation, effective communication to handle stress and managing stress</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 rationale for staffing the service. Staffing rosters were sighted, and staff are on duty to match needs of different shifts and needs of individual residents. The owner/manager works full-time from Monday to Friday and the clinical nurse manager works part-time for 30 hours across the week. The clinical nurse manager is available on call to provide afterhours cover for any clinical issues. The administration manager is available on call to provide afterhours cover for any operational issues. Interviews with the residents and family members confirmed staffing overall was satisfactory.</p> <p>At the time of the audit there were 40 residents in the rest home. The owner/manager and clinical nurse manager are supported by one RN from 7 am to 3 pm. The RNs are supported by four HCAs from 7 am to 3 pm on the morning shift. On the afternoon shift there are three HCAs from 3 pm to 11 pm. There are two HCAs are on duty overnight from 11 pm to 7 am for the whole facility. The HCAs interviewed stated that they have sufficient staffing levels. There is always a minimum of one care staff trained in first aid on duty.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded,</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration.</p>

current, confidential, and accessible when required.		
<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>The service has an information pack available for residents/families at entry.</p> <p>Rest home level of care and residential disability - physical: There are policies and procedures to safely guide service provision and entry to services including an admission policy. The admission agreements reviewed met the requirements of the contracts. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated. The respite resident had a signed short-term admission agreement. All potential residents have a needs assessment prior to admission.</p> <p>Mental health: Residents are referred to the service from the inpatient mental health unit at the district health board (DHB). Staff at the DHB identify the resident as requiring residential care and support, and both the DHB, the managers at the service and the potential resident meet to discuss appropriateness of the service to meet the potential resident needs. An assessment is completed by the DHB staff prior to the resident being admitted and this includes a risk assessment and plan.</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>Policy describes guidelines for death, discharge, transfer, documentation, and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Communication with family is made at any point of transfer, exit, discharge, or transition.</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>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. Staff stated that if a resident were to self-administer medications, then they would be provided with a locked box with a signed contract/consent for self-administration in place. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and packed system. Medications are checked on arrival and records kept on the electronic system and on a paper record that records reconciliation. Any pharmacy errors are recorded and fed back to the supplying pharmacy. RNs and medication competent HCAs administer medications. Staff attend annual education and have an annual medication competency completed.</p> <p>The medication fridge and room temperatures are checked weekly and are within appropriate range as per policy. Eye drops are dated once opened.</p>

		<p>Staff sign for the administration of medications on the electronic system. Fourteen medication charts were reviewed (six rest home; four mental health and five for residents with a disability – physical including one respite care). Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted. The respite resident had a medication chart in place and administration was recorded on a signing sheet. Appropriate practice was demonstrated on the witnessed medication around.</p> <p>All medications are stored safely in a locked trolley and in a locked medication room. Expired medication is returned to the pharmacy on a weekly basis.</p> <p>Continuity of treatment and support is promoted by ensuring the views of the resident, their family/whānau of choice where appropriate and other relevant service providers, for example GPs and the mental health team members are considered and documented prior to administration of new medicines and any other medical interventions as described by the GP interviewed and by residents interviewed.</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>	FA	<p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly and are within normal range as per policy. Food temperatures are checked, and these were all within safe limits.</p> <p>The service has two cooks who cover Monday to Sunday. Both have current food safety certificates. The main cook oversees the procurement of the food and management of the kitchen.</p> <p>There is a well-equipped kitchen, and all meals are cooked on site. Meals are served from the kitchen. The temperature of the food is checked before serving. Special equipment such as special utensils are available. On the day of audit meals were observed to be well presented. Residents and family stated that they enjoyed the food. There is an annual food satisfaction survey that was completed with a resident stating that they were satisfied.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Copies are in the kitchen and there is a whiteboard that records allergies and type of food (e.g., pureed). Changes to residents' dietary needs have been communicated to the kitchen. The four weekly menu cycle is approved by a dietitian.</p> <p>The food control plan was verified on 19 May 2020.</p>
Standard 1.3.2: Declining	FA	The service records the reason for declining service entry to prospective residents should this occur and

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Aged Care, residential disability, and mental health: Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term rest home residents whose files were sampled. Overall, the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) pain, nutrition, falls risk and pressure injury risk. A registered nurse assessment is completed for all residents as part of the initial assessment process. The service is moving to include an interRAI assessment for all residents in the future.</p> <p>An assessment was completed by the service for the resident using respite level of care and an ACC assessment and support plan was also documented.</p> <p>A comprehensive assessment including a risk assessment was provided by the referring mental health service as part of the admission process. The service also completes an assessment at six monthly intervals.</p> <p>The managers have developed links with cultural support teams. The staff recognised the strong connections with Maori for one resident and encouraged involvement with the traditional healers. The resident used kawakawa leaves with support by the service to keep this and other cultural practices alive.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Rest home level of care and residential disability – physical: The needs identified in the interRAI assessments are reflected in the care plans reviewed. All care plans were developed with the resident and family when appropriate and were resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Examples of short-term care plans documented for infections, fragile skin, rashes, graze. Short-term care plans were signed off when resolved or transferred to a long-term care plan if ongoing.</p> <p>Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals</p>

		<p>including the wound care nurse, dietitian, and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</p> <p>Mental health: Lifestyle plans are documented for residents who have mental health issues. All care plans include a section on mental health, and each includes individualised strategies to support mental wellbeing. The lifestyle care plans reflected a recovery-based approach. Early warning signs and relapse prevention plans have been included in the lifestyle care plan.</p> <p>Plans for residents with mental health diagnosis included identification of early warning signs and relapse prevention. The planning process is facilitated by staff and developed in partnership with the resident, and family/ whānau if appropriate. Residents interviewed with mental illness described the planning process and stated that they were fully engaged. Staff were also able to describe triggers and how these were managed to prevent issues escalating.</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>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>There are four wounds currently being managed in the facility. These include a blister (short term care plan documented), chronic wound with the doctor actively engaged in review of this, skin that has broken down as a result of poor hygiene (a period of homelessness led to a breakdown of skin) and a graze from a fall (with a short-term care plan documented). Two pressure injuries for one resident were signed off as resolved on the day of audit. All wounds are assessed, a wound management plan documented, and wound evaluation forms are in place. Wound monitoring occurs as planned.</p> <p>Pain assessments are completed for those residents with chronic pain. The RNs report to the GP on pain management so changes to medication for pain can be made if required.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p> <p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status.</p> <p>Mental health: Interviews with staff, residents and family members showed that interventions were tailored to the individual needs of residents. This included plans to improve independence, strategies to reduce anxiety and the provision of medication regimes. Behavioural issues were documented with</p>

		<p>plans to address challenging behaviour. Ongoing medical and mental health interventions were provided as per the care plans. Staff use early warning signs to alert them to any escalation of mental health issues and consult with mental health teams whenever they notice the signs or triggers emerging.</p> <p>All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed. The GP confirmed that the clinical nurse manager and the RNs escalate issues in a timely manner. They also verified that medical orders are followed, and care is to a high standard.</p> <p>The service has worked to eliminate any stigma and to encourage all residents to engage with each other and participate in activities together. This was observed on the days of audit.</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>	PA Low	<p>There is an activities coordinator who has been in the role for 13 years and works forty hours a week from Tuesday to Saturday. A second activities coordinator works on Monday only and fills in if required and if the other activities coordinator is on leave. On the days of audit residents were observed playing cards and games and accessing the community with support from the activity's coordinator.</p> <p>There is a weekly programme that includes quizzes; puzzles; exercises and a walking group; games; community outings (e.g., to cafés, RSA; van rides; 10 pin bowling; movies. The activities coordinator keeps a daily note in an exercise book of each day's activities and residents who have participated. Residents stated that they enjoy the outings particularly and are encouraged to be independent.</p> <p>Residents have a social assessment and history completed when they come into the service. The ongoing assessments and long-term care plan identify individualised goals for activity. Activities in the care plan are reviewed as part of the six-monthly reviews or as changes occur.</p> <p>The generic activities plan developed by the activity's coordinator does not identify specific activities for groups in the service (e.g., older aged residents, those with mental illness, people with disability, young people). A log of individual participation in the activities programme is not recorded in a way that easily allows staff to identify those residents who are not participating or who have not been on outings etc. The activities plan does not reference the individual's specific interests, goals, community participation or skills.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	FA	<p>Rest home and residential disability – physical: All long-term plans reviewed had been evaluated by the clinical nurse manager or registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, general practitioner, and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family</p>

<p>manner.</p>		<p>members interviewed confirmed that they are informed of any changes to the care plan. Individual activities plans are evaluated six-monthly by the clinical nurse manager. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Mental health: Lifestyle care plans had been reviewed and evaluated six-monthly. Medical reviews occurred three-monthly for all residents. Psychiatric reviews were done at least six-monthly. The service is using the interRAI for reassessment of the resident. Outcomes are measured through the evaluation process with input from a range of stakeholders, including residents, clinicians (including the mental health team), and family/whānau if appropriate.</p> <p>Progress notes are documented by the caregivers at the end of each shift and RNs document in the residents notes by exception (link 1.3.3.4).</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the mental health services, a podiatrist, physiotherapist, and the dietitian. Discussion with the clinical nurse manager and the registered nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as 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>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 18 November 2020. A maintenance staff member takes responsibility for refurbishing rooms and day to day repairs with other issues resolved by external trades people as required. They also garden and maintain the external areas. The</p>

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>owner/manager provides oversight overall.</p> <p>Electrical equipment has been tested and tagged and medical equipment calibrated annually as per schedule. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. Floor coverings are appropriate to resident needs and they are easy to clean. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas and gardens are well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. Garden areas were well used on the days of audit.</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 communal toilets and showers with appropriate fixtures, fittings, and flooring. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are signs on all shower/toilet doors that denote vacant or in use. One resident with a wide wheelchair was asked if they could negotiate toilet and shower areas and they stated that there was sufficient room and railings to support them to attend to activities of daily living.</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>Each resident has a single room. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the days of audit. Bedrooms also have equipment that is individualised if required. One resident who is very partially sighted and deaf has a button in the corridor and if staff wish to enter, they press this. This vibrates and the light turns on to alert the resident.</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</p>	<p>FA</p>	<p>There is a large room that is the main activities room. There is also a dining room. There are other areas both inside the facility and outdoors for quiet space. Residents stated that at times, the large lounge is busy with a variety of activities taking place and if they want a quiet area, then they use their bedroom.</p>

their relaxation, activity, and dining needs.		
<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>All laundry is done on site. The laundry staff interviewed were able to clearly define dirty and clean areas. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away. All chemicals on the cleaner's trolley were labelled. There is a sluice in the laundry for the disposal of soiled water or waste and the sluicing of soiled linen if required. The laundry is locked when not in use.</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>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months (at a minimum). The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A back up barbeque is in place.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked regularly by maintenance.</p> <p>There is a minimum of one staff member available twenty-four hours a day, seven days a week with a current first aid/CPR certificate. The facility is secured at night. Access by public is limited to the main entrance</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 bedrooms and communal areas have ample natural light and ventilation. The facility uses panel heaters and staff and residents interviewed stated that this is effective. All indoor areas are smoke free and there is a designated smoking area outside for residents who wish to smoke.</p>
<p>Standard 3.1: Infection control management</p>	FA	<p>There are clear policies and procedures for infection, prevention and control which minimises any risk of infection to residents, staff, and visitors. Infection control management is appropriate to the size and</p>

<p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>scope of the facility.</p> <p>There is an infection control coordinator (clinical nurse manager) who is responsible for infection control across the facility. The coordinator liaises with and reports to the manager. The responsibility for infection control is described in the job description. The coordinator collates monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator and the manager.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks.</p> <p>There are clear guidelines for staff and residents around Covid-19. Changes are communicated to staff at handovers and through written news bulletins. Staff have to sign when they have read the bulletins.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IC coordinator is a very experienced registered nurse, and they have access to infection control expertise within the district health board. This includes access to the wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.</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 infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies were developed by an external infection control specialist.</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>The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have participated in IC education in the last year and there is more training planned for 2020. There was particular emphasis on hygiene and personal protective equipment (PPE) during Covid-19 lockdown. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</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>The infection control coordinator is responsible for the surveillance programme of infections. Standard definitions, types of infections are documented to guide staff. Information is collated monthly and clearly documented in the infection log maintained by the infection control coordinator. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Infections are investigated, and appropriate plans of action were sighted in meeting minutes. The surveillance results, trends and analysis are discussed at the staff and registered nurse meetings. Monthly data is benchmarked (by the aged care consultant) with reports and graphs generated for the service. Infection control data is discussed with management and staff. Corrective actions are developed for any areas of concern. The outcomes of surveillance are used to identify areas for improvement and training needs for the service. Internal audits have been conducted and included hand hygiene and infection control practices.</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>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. At the time of the audit the service had one resident using a restraint (bedrail) and no residents using an enabler. The care plan for the resident file using a restraint reviewed was up-to-date and provided the basis of factual information in assessing the risks of safety and the need for restraint.</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</p>	<p>FA</p>	<p>A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to an RN. Staff receive training in restraint minimisation and challenging behaviour management.</p>

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.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. One resident file where restraint is being used was reviewed. The file included a restraint assessment and consent form. The completed assessment considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only through the night and as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Restraint use is reviewed monthly during the operation/H&S meetings. The review process includes discussing whether continued use of restraint is indicated.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed at least six-monthly as part of restraint evaluations. The service has actively worked on minimising the use of restraint.

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 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	There is an incident reporting policy that includes definitions and outlines responsibilities. Twelve accident/incident forms were reviewed. The accident/incident forms reviewed documented timely RN review and follow-up; however, neurological observations were not completed for six unwitnessed falls with a potential head injury.	Neurological observations were not completed for six unwitnessed falls with a potential head injury.	<p>Ensure that neurological observations are completed for any unwitnessed falls with a potential head injury.</p> <p>90 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that</p>	PA Low	Progress notes are documented by the HCAs at the end of each shift. RNs document in the residents notes by exception with most showing that there was a gap of 10 days before the	RNs do not document checks of residents in the progress notes unless there is an exception to the norm.	Ensure that RNs document notes to confirm they have sighted the resident and identified

<p>promotes continuity in service delivery and promotes a team approach where appropriate.</p>		<p>registered nurse entered further notes.</p>		<p>any issues or concerns at regular intervals.</p> <p>90 days</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>The activities coordinator completes a social assessment and history for the resident on admission. The long-term care plan documented by the clinical nurse manager documents goals around activities with interventions documented. A generic activities plan is put together by the activity's coordinator; however, this does not link to the individual goals documented in the care plan or reflect one-to-one activities or activities for specific groups of people (e.g., for those with mental illness).</p> <p>The activities coordinator keeps notes in a book recorded on a daily basis, however, these are not documented in individual resident records and attendance records are not recorded in a way that allows for identification of those who do not attend.</p>	<p>(i). A generic activities plan is documented and reviewed every six months; however, this plan has no reference to the individual's specific interests, goals, community participation or skills; does not reflect one-to-one activities for those who cannot or have difficulty with group activities; or reflect activities for small groups of people with similar interests or needs.</p> <p>(ii). Individual records and attendance are not documented in a way that can be used to identify residents who may not attend, who may have deteriorated in their ability to participate and who may need individual or small group activities versus generic activities.</p>	<p>(i). Review the activities plan to ensure that it reflects tailored activities for small groups of people with similar interests, for one-to-one activities, and to reflect individual goals documented in care plans.</p> <p>(ii). Document individual records and attendance at activities in a way that can be used to identify residents who may not attend, who may have deteriorated in their ability to participate and who may need individual or small group activities versus generic activities.</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.