

# Tamahere Eventide Home Trust - Atawhai Assisi Home and Hospital

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## Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Tamahere Eventide Home Trust
<b>Premises audited:</b>	Atawhai Assisi Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 9 March 2021    End date: 10 March 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	81



# Executive summary of the audit

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## 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

Assisi Atawhai Home and Hospital provides rest home and hospital level care for up to 86 residents. The service is operated by The Tamahere Eventide Home Trust Board and is managed by a chief executive officer (CEO) and general managers (GM). The most significant change to governance and operations since the previous audit in February 2019, is the appointment of a new GM who works on site Monday to Friday and two new trustees.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the Waikato District Health Board (WDHB). The audit process included review of documents including residents' and staff files, observations and interviews with residents, family members, managers, staff, a general practitioner (GP) and a nurse practitioner who was onsite. Residents and their families spoke positively about the care provided.


There was one criterion rated as partially attained which requires two improvements. Both of these relate to resident care 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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Implemented systems and the environment is conducive to effective communication. The complaints management system meets the requirements of the Code and is known by staff, residents and their families. There have been no serious complaint investigations since the previous audit. Families reported that staff immediately respond to and begin to address any concerns they raise

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. Experienced and suitably qualified people manage the services being delivered.

The quality and risk management system includes monitoring service delivery and other operations against key performance indicators. Quality improvement data is collected and benchmarked nationally. Outcomes are analysed for trends and lead to improvements. Staff are involved, and feedback is sought from residents and families.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. These were current and are reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training, supports safe service delivery and includes regular individual performance review.

Staffing levels and skill mix meet the changing needs of residents.

## 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 service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. There are policies in place to support assessment, planning, provision of care, evaluation, and transfers for residents to safely meet the needs of the residents and contractual requirements.

Residents have interRAI assessments completed and individualised care plans related to this programme. All care plans are evaluated at least six monthly.

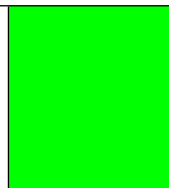
The service provides planned activities meeting the needs of the residents as individuals and in group settings.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a six-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

Medication policy identifies current best practice for medication management. Staff who administer medication have completed a medication competency in the last 12 months.

## 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.

There have been no changes to the structure of the buildings since the previous audit. Building improvements for safety and enhancements are ongoing. There is a current building warrant of fitness.

## 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.

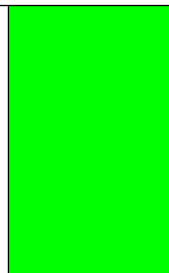


Standards applicable to this service fully attained.

Restraint processes adhere to this standard. On the days of audit there were six residents in the hospital with restraint interventions in place and six residents in the rest home using enablers (bed levers) voluntarily to assist them with positioning in bed.

## 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.

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	15	0	1	0	0	0
<b>Criteria</b>	0	40	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns.</p> <p>The complaints register contained one complaint received since the previous certification audit in 2019 and there were no known complaints to the office of the Health and Disability Commissioner. Records and interview with the GM revealed that a letter of acknowledgement, ongoing communication and investigations into the matter had been completed within acceptable timeframes. The complaint was resolved and closed.</p> <p>The GM is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their relative's status, and were advised in a timely manner about any incidents or accidents. Communication about the outcomes of, and invitations to participate in regular or urgent medical reviews were forthcoming. This was supported in the residents' records reviewed. Staff and the managers interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p>

<p>an environment conducive to effective communication.</p>		<p>There is a clear interpreter policy and staff know how to access interpreter services when required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of Tamahere Eventide Trust the organisation who operate Atawhai Assisi and the Eventide Home and Hospital. The documents described annual and longer-term objectives and the associated operational plans. Interview with the CEO and a sample of reports to the trust board showed adequate information to monitor performance is reported including emerging risks and issues.</p> <p>The CEO who has overall responsibility for both facilities has been in the role for 30 years. The organisational structure was recently reviewed which resulted in some changes within the senior management team. A new GM has been appointed to be on site at Atawhai Assisi during business hours. The previous system of having one GM care for services across two sites was proving to be unsustainable. The new GM is a registered nurse who has been employed by the trust for five years and until recently was the clinical nurse leader for dementia care. Responsibilities and accountabilities are described in a job description and individual employment agreement. Senior management interviewed demonstrated knowledge of the sector, regulatory and reporting requirements and attend ongoing education in management and/or the clinical care of older people.</p> <p>The organisation holds agreements with Waikato DHB for aged residential care-rest home, hospital and palliative, respite services, long term support-chronic health conditions (LTS-CHC) and a community day programme.</p> <p>On the days of audit there were 81 residents occupying beds. Thirty-five were assessed as requiring rest home level care, which included four respite residents. There were forty-six hospital level care residents including one respite resident and two LTS-CHC residents under 65 years of age. These numbers were consistent with the level of care report held in the interRAI system</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</p>	<p>FA</p>	<p>Staff at Atawhai Assisi are now conversant with the quality and risk systems in use across both care facilities. Responsibility for quality is shared across the senior management team with staff input at various stages. The system includes collation of key performance indicators/quality data which is submitted quarterly for comparison with like size age care facilities across New Zealand. The CEO and the GM review and analyse all incidents, infections and complaints, and the results of resident and family satisfaction surveys for trends or areas requiring improvement. When these are identified, causes are researched and remedial actions are agreed and implemented. The organisation has robust systems for monitoring of service and organisational performance. Outcomes of service performance monitoring are shared with all staff. This was evidenced in staff meeting minutes, in memos and communication books and by information displayed in staff areas.</p> <p>Quality data and information is reported and discussed at regular staff meetings for example, monthly RN meetings, wing meetings for caregivers in the hospital and rest home, allied health staff, and the health and safety</p>

improvement principles.		<p>representatives. Staff reported their involvement in quality and risk management activities through audit activities, training and information shared at meetings. The GM keeps staff informed about areas requiring improvement or policy/process changes by memos and verbally at meetings. Results of the 2020 resident satisfaction surveys showed no significant issues and a satisfaction rating of 84.28%.</p> <p>The policies used are a generic system moderated by an external quality consultant and these cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>A current risk management plan is monitored by the CEO and the Board. All senior management staff are conversant with the Health and Safety at Work Act (2015) and demonstrated knowledge of the requirements for identification, monitoring, review and reporting of risks and development of mitigation strategies. The site hazard register had just been reviewed by an external health and safety consultant.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There were well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed these are reviewed and discussed at staff meetings and then trended and further evaluated quarterly by the CEO and other senior managers. Avoidable events are evaluated and actions are implemented to prevent recurrence.</p> <p>Interviews and review of incident data confirmed that incidents are discussed at shift handover, and trending data is displayed in staff areas. Each resident's care record contained a summary of incidents which facilitates a ready review of risks.</p> <p>The CEO is responsible for essential notifications and reporting and understood the statutory and regulatory obligations. Section 31 notifications have been submitted for changes in board membership, and the new GM. There had been no incidents which required notification since 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	FA	<p>Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The staff records sampled confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>All new staff have one to one time with the clinical nurse educator (CNE) before starting work and then return for a mandatory orientation day which occurs monthly. An orientation day was in process on day one of this audit. New staff reported that the orientation process prepared them well for their role. Staff records showed documentation</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>of completed orientation followed by an initial performance review after 90 days.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. All care staff are expected to commence age care sector training (as outlined in their pay equity settlement) three months after commencing employment if they do not already have qualifications. The CNE is an authorised moderator of the education programme provided on site. On the days of audit, 27 of the 60 carers had completed the Limited Career Pathway-dementia module, thirteen had achieved level 4 of the National Certificate in Health and Wellness, 17 had completed level 3 and two were at level 2.</p> <p>Each of the staff files sampled contained evidence of annual performance appraisals.</p> <p>Fourteen of the seventeen RNs (including the CNL and GM) employed are maintaining annual competency requirements to undertake interRAI assessments.</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 are more than the required numbers of staff allocated (as per the ARC contract) on each shift in the rest home and hospital wings.</p> <p>A full time clinical nurse leader (CNL) oversees the care being delivered to rest home residents Monday to Friday, along with another CNL who oversees hospital level care.</p> <p>The rest home roster has four caregivers for the morning and afternoon shift (plus the CNL and an EN or RN) and an RN and caregiver at night. The hospital wing has 10 caregivers for the morning shift and eight in the afternoon (plus the CNL and two more RNs) with three caregivers and one RN at night.</p> <p>The majority of staff work four days on and two days off. Caregivers are employed for guaranteed minimum hours of 31.5 hours and RNs for 37.3 hrs per week. A total of 13 RNs and two enrolled nurses allows for four RNs (plus the CNLs) to be on site for all morning and afternoon shifts and an RN on call after hours. There are two RNs on site at night and at least six staff members with a current first aid certificate on duty at all times.</p> <p>The care staff interviewed said there were sufficient numbers of staff, for the needs of the residents, allocated across all shifts. Additional staff are rostered on when workloads increase for any reason. Reports showed agency staff usage has decreased.</p> <p>The service employs an appropriate number of dedicated auxiliary staff (for example, activities, rehabilitation, cooks, cleaners, management, administration and maintenance staff) for the size and scope of the service. Residents and family members interviewed expressed satisfaction with the availability of staff and the services provided.</p>
<p>Standard 1.3.12:</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with</p>

<p>Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. Vaccines are not stored on site.</p> <p>There were five resident who self-administered medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a head chef, two supporting cooks and kitchen staff and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Waikato District council and expires 9 May 2021. A food safety verification audit was undertaken by the Waikato district council on the 11 November 2020 with no corrective actions identified. The next audit is due 22 April 2022. Food temperatures, including for high-risk items and the cleaning schedule is monitored appropriately, and recorded as part of the food control plan. The head chef has undertaken a safe food handling qualification, with supporting cooks having relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile</p>

		<p>developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. There are 19 residents currently being supported by a menu provided by Pure foods which is an external company supporting residents requiring a nutritious softer textured menu. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP and NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and the care provided is resident centred. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is overseen by an allied health co-ordinator trained in sports and exercise and supported by three trained diversional therapists. Two of the diversional therapists (DT) support residents in the hospital area, the third DT supports residents in the rest home. The diversional therapist holds a national Certificate in Diversional Therapy. The team of four work Monday to Friday between the hours of 9.30 am and 4.00 pm.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated if any changes are identified and as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through day-to-day discussions with residents and family. There is a separate activities calendar for hospital and rest home residents with some combined activities. Information about the activities was observed on day of audit on the notice boards and in the residents' bedrooms. Residents interviewed confirmed that 'there is always something to do' and find the programme busy, fun and interactive.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Not all care plans evaluated have oversight of a registered nurse (see criterion 1.3.3.1). Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The current building warrant of fitness expires 12 May 2021. There have been no changes to the structure of the buildings. All buildings, plant and equipment inspected during the audit were in good condition and showed evidence of being well maintained. Extensive remedial work on the interior and exterior of the buildings is ongoing. There have been no incidents related to the environment.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator role is shared between the general manager and clinical nurse leader for the hospital. Together they review all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and is reported by General Manager whom they reports back to all staff.</p> <p>The facility has had a total of 61 infections since September 2020. Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.</p> <p>Learnings from the Covid-19 pandemic have been incorporated into practice, with additional staff education implemented.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The organisations restraint minimisation and safe practice policies and procedures meet the requirements of this standard and provide guidance on the safe use of both restraints and enablers. The CNL for the hospital is the nominated restraint coordinator, and the role and responsibilities are documented. This person provides support and oversight for enabler and restraint management throughout the facility and demonstrated a sound understanding of the organisation's policies and procedures and the practices required from this standard. On the days of audit six hospital residents were using restraints. This included three with bed rails, one using a lap belt, and two requiring chair harnesses when sitting. Six rest home residents had voluntary enablers in place, these were all bed levers to assist them with positioning.</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 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	PA Low	<p>The rest home clinical nurse leader interviewed stated that both registered and enrolled nurses are responsible for developing residents’ long term care plans. This information is gathered from the residents’ interRAI assessments/summaries and triggered clinical assessment protocols (CAPs), progress notes, other supporting documents, and discussions with other staff. The care plans observed on the day were individual and specific to the resident and identified all needs required to support the resident while maintaining their independence. Residents and families interviewed were happy with the care provided. Care plans allocated to and developed by the enrolled nurse are not signed off by a registered nurse. The outcome generated scores created from the interRAI assessments are documented in the residents’ electronic progress notes but not identified in the residents’ care plans.</p>	<p>There is no documented evidence that the long-term care plans created by the enrolled nurse are signed off by a registered nurse.</p> <p>InterRAI assessment</p>	<p>Provide evidence that a registered nurse agrees to and signs of all resident care plans as per contractual requirements and scope of practice.</p> <p>Ensure</p>

			outcome scores to support decision making for goals and interventions are not identified in the long-term care plans.	outcome scores generated by the interRAI assessment are documented in the long-term care plans.  90 days
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.