

Sunrise Healthcare Limited - Lynton Lodge Hospital

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:	Sunrise Healthcare Limited
Premises audited:	Lynton Lodge Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Residential disability services - Physical
Dates of audit:	Start date: 27 May 2021 End date: 28 May 2021
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:	31

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Lynton Lodge Hospital is certified to provide hospital (geriatric and medical) level care and residential disability services – physical. There were 31 residents at Lynton Lodge on the day of audit.

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

There is a facility manager (director) who provides oversight of Lynton Lodge and three other facilities. The second director also provides support for operational management. The clinical manager is full time at Lynton Lodge.

The service has an established quality and risk management system. Overall residents and family interviewed, commented positively on the standard of care and services provided. Since the last audit, the service has introduced monthly checks to ensure that interRAI assessments are up to date.

This audit has identified areas for improvement related to the quality programme, the complaints register, and to restraint.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights 'the Code' and copies of the code are displayed throughout the facility. There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents, and family verified the service is respectful of individual needs, including cultural and spiritual beliefs. There are implemented policies to protect residents from discrimination or harassment. There is a complaints policy supporting practice and a record of documentation around complaints is retained. Manager and staff interviews confirmed an understanding of the complaints process.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The service is managed by appropriately trained personnel and there is a suitable structure in place to oversee service delivery in the absence of the manager. There is a facility manager (director), second director, and a clinical manager who provide operational

management for the service. There is a documented quality and risk management programme. Corrective action plans are documented if issues are raised. Meetings are in place to discuss aspects of the quality programme.

There is a human resource manual to guide practice. Staff files were reviewed, and all had a current appraisal and showed human resource practices are followed. There is a documented rationale for staffing the service. Staffing rosters were sighted and healthcare assistant staff on duty match needs of different shifts and individual resident needs. Resident information is kept confidential and old records are archived.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The 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/whānau input. Care plans viewed demonstrated service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The activities coordinator implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks 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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The building holds a current warrant of fitness. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Cleaning and laundry services are monitored through the internal auditing system.

Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

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.		Some standards applicable to this service partially attained and of low risk.
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There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were three residents with restraints and four residents requiring an enabler at the time of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control resource nurse (RN) is responsible for coordinating education and training for staff. The resource nurse has completed annual training through an online provider in addition to ongoing Covid education provided by the local DHB. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator resource nurse and clinical manager use the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	46	0	2	2	0	0
Criteria	0	97	0	2	2	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>Lynton Lodge has an implemented code of rights policy and procedure. Discussions with staff included three healthcare assistants across all levels of care and all shifts and one physiotherapy assistant; two registered nurses; household staff including, a cleaner, kitchen manager, maintenance staff; and one activity coordinator. The audit team also interviewed the director, facility manager (director) and clinical manager (CM). All interviewed confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights 'the Code'.</p> <p>Interviews were held with eight hospital residents including one young person with a disability (YPD) and one under a Long-Term Support – Chronic Health Condition (LTS-CHC) and five relatives including one with a family member under ACC and two with a resident identified as being a YPD. All confirmed that the service is provided in line with the Code apart from three family members (two with the same family member).</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</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in the six hospital resident files were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advance directives and/or resuscitation status are signed for separately by the competent resident.</p>

<p>need to make informed choices and give informed consent.</p>		<p>Copies of EPOA are kept on the residents file where required and activated where necessary. Healthcare assistants and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Six resident files sampled have signed admission agreements.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There is an advocacy policy and procedure that includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy and advocacy pamphlets are available at reception. Residents are provided with a copy of the code and Nationwide Health and Disability Advocacy services pamphlets on entry.</p> <p>The resident file includes information on resident's family/whānau and chosen social networks.</p> <p>Discussion with relatives identified that family/enduring power of attorney (EPOA) are involved in decisions and they are happy with the level of involvement currently.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The client information pack informs that visiting can occur at any reasonable time. Interviews with residents and relatives confirmed that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans.</p> <p>The service supports each resident to maintain relationships with their family, friends, and community groups. This includes encouraging them to attend functions and events and helping to ensure that they are able to participate in as much as they can safely and desire to do.</p> <p>Resident meetings are held three-monthly, and family can participate if they wish to. There is evidence of appropriate and frequent communication with family members and residents throughout the Covid-19 pandemic lockdown periods.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are readily available.</p> <p>Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were also</p>

		<p>able to describe the process around reporting complaints.</p> <p>A complaints register is not maintained although a record of formal complaints when documented is retained. There was one complaint documented in 2020 and three complaints for 2021. Two were fully investigated by the facility manager and director. A complainant for one complaint in 2021 had the support of the independent advocate and a letter from the Nationwide Advocacy Service confirmed that the complaint had been resolved with no actions required by the service. The service had responded to the third complainant and had thought that the complaint had been resolved. The complainant interviewed stated that the complaint was still open.</p> <p>The facility manager, director and clinical manager interviewed could confirm knowledge of the complaints process and stated that they inform residents and family on entry to the service. The staff also stated that if there is a complaint, then they offer the resident or family a form to document their concerns and inform the registered nurse or clinical manager.</p> <p>The district health board raised specific concerns they had received from a resident around food services. There is no evidence to substantiate the complaint. There have not been any other complaints from other external authorities.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information to residents that includes the code of rights, complaints, and advocacy information. Information is given to next of kin or EPOA to read to and/or discuss with the resident. Interviews with residents and relatives identified they are well informed about the code of rights. The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy, and Health and Disability Commission information. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care, respects their rights and maintains privacy and individuality.</p> <p>The clinical manager and staff support residents to go to their choice of spiritual/religious advisors with the support of family. Residents and family were asked if they wished to have services on site, however when these were offered, residents did not attend. Religious dietary requirements when identified through assessment and care planning are met as required. Discussions with residents confirmed the staff are respectful and that their privacy is respected, and that cultural and/or spiritual values and individual preferences are identified. Care plans reviewed identified specific individual likes and dislikes.</p>

		There is an implemented abuse and neglect policy. Staff have completed training around abuse and neglect as part of orientation and ongoing training and could describe appropriate practices to prevent and identify any abuse or neglect. There have not been any incidents related to abuse or neglect in the past year. The general practitioner (GP) praised the service for the way services were delivered and stated that there was no evidence of abuse or neglect.
<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	There is a specific Māori health care plan and a culturally safe care policy. The service has no residents who identify as Māori. Discussions with staff confirmed an understanding of the different cultural needs of residents and their family. There is a section in the assessment and care plan that includes spirituality, religion and culture, psychosocial needs and family and significant others. The clinical manager stated that assessments and care plans would reflect the needs and interventions for any resident who identified as Māori. The clinical manager stated that they would link with the district health board if they required advice or support for Māori.
<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 includes consideration of spiritual, psychological, and social needs. Residents indicated that they are involved in the identification of spiritual, religious and/or cultural beliefs. Family involvement is encouraged. There are no residents who require the use of an interpreter. Staff were observed to communicate with residents who have cognitive decline even if there is no response due to the residents declining health. Staff are also able to describe how they watch for any body language that identifies specific needs (e.g., one resident cannot communicate except with hand movements that the staff now recognise).</p> <p>Care plans reviewed included the residents' social, spiritual, cultural, and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There is a comprehensive and implemented discrimination and harassment policy in place. Job descriptions include responsibilities of the position and ethics, advocacy, and legal issues. The orientation programme provided to staff on induction includes dignity and privacy. Interviews with staff informed an understanding of professional boundaries. A staff code of conduct is discussed during the new employee's induction to the service and is signed by the employee. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.</p> <p>Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. A staff employment</p>

		<p>handbook and orientation package includes training around professional boundaries.</p> <p>Residents interviewed felt that they were not exposed to exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has implemented policies and procedures to provide assurance it is adhering to relevant standards. The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staff are informed when external training is available. There is access to computer and internet resources.</p> <p>The service has a high acuity of residents at hospital level of care. Staff are knowledgeable about care that is to be provided to each individual resident. Staff interviewed are passionate about the care they provide.</p> <p>The service has responded to the Covid-19 pandemic well with communication to family and residents relevant to public health directives, extra staff training in use of personal protective equipment and infection control measures, and monitoring to ensure that family and others are kept safe when visiting.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, the complaints procedure, and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney and the resident of any accident/incident that occurs. Evidence of contact being maintained with families, including when an incident or care/health issue arises, is documented on the accident/incident forms reviewed.</p> <p>Interviews with family members confirmed that they are kept informed, although three family members (two with one resident) were not always happy with the responses given to them.</p> <p>Interpreting services are available from an external provider and through staff and families.</p> <p>The information pack is available in large print and this could be read to residents. Residents sign an admission agreement on entry to the service. All residents stated that they are communicated with well and informed of any changes to individual care requirements or around any incidents or accidents that occur. All stated that they can see the clinical manager at any time.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are</p>	FA	<p>Lynton Lodge Hospital is certified to provide hospital (geriatric and medical) level care and residential disability services – physical. There are 40 hospital beds. There were 31 residents requiring hospital level of care on the days of audit. Six residents were identified as young people with physical disabilities funded under residential disability services, two were residents identified as requiring LTS-</p>

<p>planned, coordinated, and appropriate to the needs of consumers.</p>		<p>CHC and one was funded by ACC. All others were funded under the Age Related Care Contract.</p> <p>There are two owners (referred to as the director and facility manager) who own this facility and three other facilities. They provide input into the service with one being responsible for oversight of administration including payroll services and the other for information technology and property management. One manager visits the service during the week and can relieve for the administrator if on leave.</p> <p>There is a clinical manager (registered nurse) who provides clinical oversight at the facility. The clinical manager (CM) and staff confirmed that the director and facility manager are on site at this facility at various times during the week to support them. The clinical manager from a neighbouring facility supported the clinical manager on the day of audit.</p> <p>The clinical manager has a current practising certificate and has worked as a clinical manager at another facility for seven years. They have been in the role for two years and are supported by a clinical manager at another service close by. The CM has completed a postgraduate certificate in advanced nursing.</p> <p>There is a philosophy, values and goals documented in the quality plan. Goals are reviewed weekly, monthly, and annually. The philosophy is communicated to residents, staff, and family through information in booklets and in staff orientation and training.</p> <p>The clinical manager has attended a minimum of eight hours of professional development activities related to managing an aged care facility as confirmed through review of staff records.</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 director and facility manager state that they are always available by email or phone if away with delegation of day to day operational issues to the clinical manager. The clinical manager (RN) from a neighbouring facility close to the service owned by the same owners, covers during the absence of the clinical manager. This clinical manager was on site during the audit to provide support for the clinical manager of Lynton Lodge.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>PA Low</p>	<p>The quality and risk management programme is developed by the facility manager in conjunction with the director and clinical manager. Quality management is overseen by the organisation's facility and clinical managers.</p> <p>Policies and procedures have been reviewed two yearly or as changes have occurred. New and/or</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>revised policies are made available for staff to read and sign that they have read and understand the changes.</p> <p>There are quality goals set for the three facilities and then specific quality goals for Lynton Lodge Hospital. Progress is discussed by clinical staff and managers weekly and monthly. There is an implemented audit schedule and issues discussed at regular meetings held including monthly staff meetings, and monthly registered nurse (clinical) meetings. While issues are raised, there is a gap in documentation of corrective action plans or resolution of issues when issues are raised.</p> <p>There is monthly collating of quality and risk data with discussion at the three-monthly quality and risk meeting that includes restraint and infection control. Data is collated and analysed across the four facilities owned by the same owners to identify trends, with this discussed at the quality and risk meeting with the other managers involved. This includes review of bed occupancy; audit information; complaints; incident data; high needs; admissions; staffing and clinical case review.</p> <p>A resident and family satisfaction survey has been completed in 2021 with positive feedback from respondents. Resident meetings are expected to be held three-monthly. There have been two family/resident meetings held in 2021 with none held in 2020. These have been held as planned in 2021, however there have not been any held in 2020. The management team stated that these meetings were cancelled because of Covid-19 and lockdown. The management team stated that they are committed to having these as planned in 2021.</p> <p>Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised along with a physiotherapy assistant to progress specific interventions. The registered nurse meeting minutes and the review of the quality and risk meeting minutes confirmed that clinical issues are discussed, including strategies to prevent and manage falls.</p> <p>There is a health and safety plan for the service. The goals are reviewed through the health and safety meeting held quarterly for all sites with minutes of meetings documented. A health and safety representative is appointed, and they escalate any issues as these arise. Staff stated that they can also escalate issues to managers as required. Staff and meeting minutes confirmed that health and safety is discussed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and</p>	<p>FA</p>	<p>The service collects a set of data relating to adverse, unplanned, and untoward events, which is linked to the quality and risk management system. Immediate actions taken are documented on accident/incident forms now documented on the electronic resident database. Each incident is recorded against an individual resident, then incidents are totalled according to category. Forms (eforms) are reviewed and investigated by the clinical manager. These reviews are signed off in a</p>

<p>reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>timely manner by the clinical manager.</p> <p>There is insufficient documentation to confirm that neurological observations are fully completed for any resident who has a fall involving hitting their head or for any resident who has an unwitnessed fall (link 1.3.6.1).</p> <p>Discussions with the clinical manager confirmed their awareness of statutory requirements in relation to essential notification. The Ministry of Health has not been required to be informed of any significant issues.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Job descriptions are in place for all relevant positions that describe staff roles, responsibilities, and accountabilities. The practising certificates of nurses and visiting health professionals are kept on file and are current.</p> <p>Five staff files reviewed (the clinical manager, two registered nurses, and two healthcare assistants) confirmed that there is a signed employment contract on file, a current job description and documentation of orientation and staff training.</p> <p>Annual performance appraisals for staff are up-to-date. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with healthcare assistants who cover the morning, afternoon and night shifts confirmed that the orientation programme included a period of supervision over three days.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance is recorded. A system for determining staff competency is implemented. Competencies for registered nurses includes medication, syringe driver and insulin administration, and all staff complete infection control and restraint competencies. The clinical manager and two other registered nurses are interRAI trained with two other RNs enrolled in the training programme.</p> <p>Staff are encouraged to completed CareerForce training with the following staff having completed this: six completed level one training; three with level two training; three with level three training and two with level two training. Staff have completed training around the needs of younger people with this added into each topic.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The facility manager is on site during the week to provide support for the clinical manager who works five days a week (Monday – Friday).</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>One registered nurse is rostered onto each shift with the clinical manager taking some shifts if a registered nurse is on leave. RNs work 12-hour shifts. There are five healthcare assistants in the morning (three on a long shift and one from 7 am to 2.30 pm, one from 7 am to 1 pm); three healthcare assistants on the afternoon shift (two on a long shift and one from 3 pm to 9 pm) and two healthcare assistants overnight. The care facility is split into three wings (east, middle west, south) and staff work in pairs or allocate residents according to acuity. Acuity of residents is high with most residents requiring two hourly turns when in bed, and support for feeding and other activities of daily living. One resident has extra funded care and support during the day.</p> <p>There is a total of 25 staff including managers. Separate staff complete food services, laundry, and cleaning duties. In total, there are four registered nurses, an activities coordinator, and 15 HCAs. The clinical manager and another clinical manager at a neighbouring facility are rostered to provide on call services week about.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>There are electronic resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual electronic record. Resident clinical and allied health records are integrated. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access with staff having individual passwords. All entries in the progress notes are identifiable by date, time, writer, and designation. In the event of a computer failure, data can be accessed from the cloud.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The director and clinical manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment, and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents, and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The six admission agreements reviewed meet contractual requirements and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the facility manager and clinical manager are available to answer any questions regarding the</p>

		admission process.
<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>The service has a policy that 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. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission in to the facility.</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-medicating on the day of audit. There are no standing orders in use and no vaccines stored on site.</p> <p>The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and medication competent HCAs administer medications, have up to date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperatures are checked daily and are within the required ranges. Eye drops viewed in medication trolleys had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twelve medication charts were reviewed. 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.</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>The kitchen manager oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring May 2022. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <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 are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which</p>

		<p>identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen using a printed dietary profile from the electronic resident management system. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu is approved by an external dietitian.</p> <p>Residents and families interviewed expressed satisfaction with the meals. Additional snacks are available at all times for residents such as young people who are up later at night.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. 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 back 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>	FA	<p>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 residents' files reviewed. Six monthly interRAI assessments and reviews are evident for five of six resident files sampled as one hospital resident had not been in the service for six months.</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed on the electronic system evidenced multidisciplinary involvement in the care of the resident. Overall care plans reviewed were resident-centred (link 2.2.3.4). Interventions documented support needs and provide detail to guide care. 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, including the mental health team, dietitian, wound care specialist and PEG nurse specialist. The care staff interviewed</p>

		advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.
<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>	PA Moderate	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the standard of nursing and care provided.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included one chronic wound, one skin tear, one post-surgical wound, two cancerous lesions, one grade 2 pressure injury (facility acquired) and one grade 4 facility acquired pressure injury. There was evidence of wound nurse specialist involvement in chronic wound and pressure injury management.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds and neurological observations. However, these were not always fully completed.</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>There is one activity coordinator covering Monday to Friday who plans and leads all activities. The coordinator prepares activity resources for weekends, with resources labelled and easily identifiable for HCAs and families to utilise as required. Residents were observed participating in planned activities during the time of audit.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, cooking, crafts, games, quizzes, entertainers, pet therapy, art therapy and bingo.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as manicures, iPad based activities and hand massage are offered.</p>

		<p>There are weekly outings and the service shares a wheelchair accessible minibus with a sister facility to use as needed. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, and Anzac Day are celebrated in collaboration with the kitchen staff who provide birthday cakes and other themed goods for the residents. There are visiting community groups such as the university choir, churches, and local schools.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were very positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long term care plans are evaluated by the RNs six monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six-monthly care plan review is also completed by the registered nurse with input from HCAs, the GP, the activities coordinator, resident and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</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>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurse interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the clinical manager and registered nurse 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</p>	FA	<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 datasheets 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. A</p>

<p>as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>spills kit is available.</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 building holds a building warrant of fitness which expires May 2022. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged, expiring April 2022. The hoist and scales are checked annually and are next due to be checked March 2022. Hot water temperatures have been monitored in resident areas and are within the acceptable range. In previous audits access into the service from the foyer has been through a locked door with a numbered keypad. The service no longer uses environmental restraint and the door was found to be unlocked during the time of audit. Management confirmed this change in policy from the previous certification audit and advised the facility was only secured at night as per the security protocol.</p> <p>Flooring is safe and appropriate for residential care. All corridors 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. The external areas and decked areas are well maintained. All external areas have attractive features, including views of the nearby coast and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</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>Some resident rooms have an ensuite toilet or there are also sufficient communal toilets and showers. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of ensuites. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed</p>	<p>FA</p>	<p>There are two double rooms, all other resident's rooms are single. The double rooms have privacy curtains to provide resident privacy when required. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. One resident room has been upgraded with the addition of a ceiling hoist. Staff interviewed reported that they have more than adequate space to</p>

areas appropriate to the consumer group and setting.		provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There are large and small communal areas, with activities occurring in all areas of the facility. Residents are assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The dining areas are homely, inviting, and appropriate for the needs of the residents.
<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	All laundry is done on site. There are clearly defined clean and dirty areas. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. Sluice rooms were kept locked when not in use.
<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 and there is a New Zealand Fire Service approved evacuation scheme.</p> <p>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>There are adequate supplies available in the event of a civil defence emergency including water, food, and supplies (torches, radio, and batteries), emergency power and barbeque. The facility keeps sufficient emergency water for 3 litres per person, per day for at least 3 days for resident use on site. A gas cooker is available on the premises.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Residents were observed in their rooms with their call bell alarms in close proximity.</p>

		<p>There is always at least one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p> <p>Security policies and procedures are documented and implemented by staff. The building is secure at night.</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. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>An RN fulfils the infection control resource nurse role and has done for the past month, with the support of the clinical manager. Responsibility for infection control is described in the job description which was evidenced on the day of audit. The resource nurse oversees infection control for the facility, reviews incidents, and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed externally by a consultant who produces benchmarking which is shared between the client base. The consultant is also available for direction and advice via email and telephone. An infection control committee comprised of clinical and non-clinical staff meets three-monthly as part of the infection control strategy.</p> <p>The facility has a Covid/Pandemic plan in place and appropriate amounts of PPE on hand to last for at least two weeks in case of a further lockdown. During Covid the service held regular virtual meetings with the DHB Covid preparedness team to check policies, procedures, and service readiness.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility and Covid scanning and/or manual sign in is mandatory. Residents are offered the annual influenza vaccine. There have been no outbreaks in the previous year.</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</p>	FA	<p>There are adequate resources to implement the infection control programme at Lynton Lodge. The infection control resource nurse liaises with the infection control committee who meet three monthly and as required (more frequently during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The resource nurse has completed annual training in infection control through an online learning portal.</p>

<p>programme and meet the needs of the organisation.</p>		<p>External resources and support are available through a contracted consultant, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the infection control committee with external consultant oversight.</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 have been developed by the clinical manager with input from a contracted consultant and the DHB 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 infection control resource nurse is responsible for coordinating education and ensuring staff complete the online training available on the 'care online' internet-based education system. Training on infection control is included in the orientation programme. Staff have completed online infection control study in the last 12 months. The resource nurse has also completed infection control audits. 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>Surveillance is an integral part of the infection control programme and is described in the facility's infection control manual. The infection control resource nurse and clinical manager collate the information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed with the facility manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Results from laboratory tests are available as required. There have been no outbreaks in 2020.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked.</p> <p>Restraint is discussed at the three-monthly quality and risk meeting with benchmarking across four facilities.</p> <p>There were four residents with enablers during the audit and three residents using restraint (bed rails for two residents, and bedrails, a lap belt, helmet, and chest harness for one resident) at the time of the audit. Training around restraint minimisation, enablers and challenging behaviour has been provided as part of the orientation for all new staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The clinical manager is the restraint coordinator with a defined job description. A registered nurse is also learning the role. Restraint discussion and quality data around restraint and enabler use is included in the quality and risk meetings and clinical meetings. Care staff receive education on safe restraint use at orientation and annually. There is ongoing education including challenging behaviours. Staff complete restraint competencies annually.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The clinical manager in partnership with the GP, the resident and their family undertakes assessments. Restraint assessments are based on information in the care plan, family discussions and observations. Ongoing consultation with the family was evident. A restraint assessment form had been completed for two resident files reviewed requiring restraint (sighted). Assessments identify risks related to the use of restraint and the specific interventions or strategies to try (as appropriate) before implementing restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Low	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is</p>

		<p>responsible for ensuring all restraint documentation is completed.</p> <p>Restraint use and risks of use of the restraint are included in the two care plans reviewed. Interventions to manage the use of the restraint is not well documented in care plans. Individual restraint monitoring booklets evidence checks, and cares have been carried out, however the frequency of monitoring is not defined in care plans.</p> <p>There is an up-to-date restraint register.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluations occur three-monthly by the clinical manager with GP input and then six-monthly as part of the ongoing review as part of their care plan review. Families (where possible) and the GP and RNs are included as part of this review. Their engagement in the review process is documented. This was also confirmed with the GP interviewed and one family member whose family member used a bed rail.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraint usage is monitored monthly. The review of restraint use is discussed at the quality meetings and relevant facility meetings. The facility is proactive in minimising restraint. Internal restraint audits are completed three and six-monthly and demonstrate compliance of the standard.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>The documentation for each formal complaint is kept in a folder. Two examples of verbal complaints were raised by family or residents interviewed however these were not documented on a complaints form and therefore did not show evidence of resolution although the family or residents raising the complaints stated that these had been resolved with no evidence that the issues had been raised again. There is no summary of complaints with these expected to be kept on an up-to-date complaints register. Two family members for one resident expressed some concerns with these raised with the management team. The management team had support from the funder to address the issues and the family when interviewed stated that they</p>	<p>(i). There was no documentation relating to two verbal complaints raised by residents or family interviewed by the auditor. (ii). A complaints register is not maintained.</p>	<p>(i). Document verbal complaints raised by residents or family. (ii) Maintain an up-to-date complaints register.</p> <p>90 days</p>

		did not want to raise the issues as a complaint.		
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Issues are raised as a result of audit reports when non-conformities or partial conformities are identified. There is some evidence of resolution of issues in audit reports, however this generally states 'effective' and does not detail actions taken to resolve the issue or whether the resolution occurred in a timely manner. Corrective action plans are not well documented. Issues are raised in meeting minutes, however there is limited documentation of resolution of the issues.</p>	<p>(i) Corrective action plans are not well documented with actions, responsibilities, and timeframes when issues are identified through audits.</p> <p>(ii) There is limited documentation of resolution for a number of issues raised in audit reports and limited documentation of resolution when issues are identified at meetings.</p>	<p>(i) Document corrective action plans with actions, responsibilities, and timeframes when issues are identified through audits.</p> <p>(ii) Document evidence of resolution of issues when raised in meetings.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>There are documented requirements and timescales for recording the repositioning of residents at high risk of developing pressure injuries, however monitoring charts were not completed in a timely and consistent manner. There are clear indications, requirements and timescales related to neurological observations in the organisation's policy. Not all neurological observations were carried out and documented</p>	<p>(i).Two residents who were classified as a high risk of pressure injury did not have their positioning charts</p>	<p>(i)-(ii). Ensure all resident monitoring charts are fully completed in a timely manner and according to policy.</p>

		as per that policy.	consistently completed. (ii). Neurological observations (four of six reviewed) were not consistently documented according to organisational policy for residents with unwitnessed falls and/or a hit to the head.	60 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the</p>	PA Low	There is mention of the restraint used in the care plan, however interventions are not well documented. The frequency of monitoring is not documented in the care plan noting that the two residents with restraint reviewed had monitoring charts completed.	Interventions including frequency of monitoring when the restraint is on is not documented in the care plan.	<p>Document interventions including frequency of monitoring in the care plan.</p> <p>90 days</p>

restraint.				
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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.