

Masonic Care Limited - Horowhenua Masonic Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Masonic Care Limited
Premises audited:	Horowhenua Masonic Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 July 2017 End date: 6 July 2017

Proposed changes to current services (if any): HealthCERT has requested that specific reference to the reconfiguration of services be included in this audit. The service is currently changing part of one of the units by reconfiguring three rest home bedrooms into one dual purpose bedroom with an ensuite and two care suites under an occupied rights agreement. When completed, the total number of available beds will remain at 76.

Total beds occupied across all premises included in the audit on the first day of the audit: 70

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

Horowhenua Masonic Village can provide residential care for up to 76 residents. On the first day of this audit there were 70 beds occupied, including residents under an occupational right agreement. The facility is operated by Masonic Care Limited.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, a general practitioner and other allied health professionals.

There are no areas requiring improvement from this audit.

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.	Green	Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents, and staff were noted to be interacting with residents in a respectful manner.


Resident who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to formal interpreting services if required.

The service has strong linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The village manager and clinical nurse manager are responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

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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Masonic Care Limited is the governing body and is responsible for the service provided. A strategic business plan and quality and risk management systems are fully implemented at Horowhenua Masonic Village. The documented scope, direction, goals, values,

and a mission statement were reviewed. Systems are in place for monitoring the service provided including regular reporting by the village manager to the governing body.

The facility is managed by an experienced and suitably qualified manager who is supported by a clinical nurse manager and three charge nurses. The clinical nurse manager is responsible for the oversight of the clinical service in the facility.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, health and safety, various staff and resident meetings are held on a regular basis.


The hazard register evidenced review and updating of risks and the addition of new risks. The health and safety representative has completed an update on the Health and Safety at Work Act (2015) requirements.

There are policies and procedures on human resources management. Human resources processes are followed. Staff have the required qualifications. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are rostered on duty at all times. The clinical nurse manager, charge nurses and the village manager are on call after hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using integrated hard copy files.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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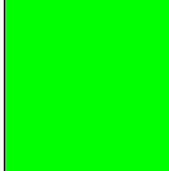
The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff and a designated general practitioner. On call arrangements for support from registered nurses are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrate that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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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All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.


Part of one of the units is currently being reconfigured to provide one bigger bedroom with a full ensuite that will be dual purpose (accommodation for rest home or hospital level care) and two care suites under an occupational right agreement.

Single accommodation is provided. Adequate numbers of additional bathrooms and toilets are available. There are several lounges, dining areas and alcoves. External areas for sitting and shading is provided.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. Laundry is washed on site and off site. Cleaning and laundry systems are audited for effectiveness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraint and one resident using an enabler during the audit. Appropriate documentation including a current restraint register was in place.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control resource nurse, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice is able to be accessed from an external infection control advisory group. The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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>Horowhenua Masonic Village has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including consent for photographs, outings, names on doors and the collection and sharing of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's records. Staff demonstrated their understanding by being able to explain situations when this may occur.</p>

		Staff were observed to gain consent for day to day care on an ongoing basis.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff are aware of how to access the Advocacy Service. A residents' advocate runs the residents' meetings, and interview verifies discussion on the service comes up at meetings. The advocate is available to assist residents with accessing services if required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and forms available throughout the facility.</p> <p>The complaints register showed 27 complaints have been received since the previous audit. Actions taken, through to an agreed resolution, was documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The village manager (VM) and the clinical nurse manager (CNM) are responsible for the management of complaints and follow up. The quality coordinator is responsible for keeping the register up to date. Staff interviewed confirmed a good understanding of the complaint process and what actions are required.</p> <p>The VM and CNM reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation</p>

		Corporation (ACC), Coroner or Police since the previous audit.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with staff and discussion with the residents' advocate at residents' meetings. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and enabling resident's opportunity for privacy when requested. All residents have a single room.</p> <p>Residents are encouraged to maintain their independence by maximising opportunities for residents to be independent, enabling participation in decisions that concern residents and participation in outings and clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. Guidance on tikanga best practice is available. The Maori health framework group operating within the facility initiates a Maori perspective in all aspects of the facilities management and are recognised as an integral part of the day to day operations. Local Maori health services support the organisation. Two residents who identified as being of Maori descent, had their needs to not identify with the Maori culture recognised. Their culture was about</p>

		being free to access family and spiritual needs as and when they saw fit.
<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>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supported that individual needs are being met.</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>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their employment agreement. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, physiotherapist, tissue viability nurse, dietician, services for older people, occupational therapist, speech language therapist, infection control advisors and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and have access to on line learning sites to support contemporary good practice. Three RNs have the support of the organisation to undertake post graduate training to enable improved resident outcomes around medication management and prescribing.</p> <p>Other examples of good practice observed during the audit included evidence of the organisation's commitment to improving the provision of quality care in aged care.</p>

		<p>The organisation is working in collaboration with the local District Health Board (DHB), other aged care providers and the hospice to pilot a project focussing on supportive education and quality palliative care (Sequal). The organisation is involved in trialling a variety of initiatives to identify the best management strategies to ensure quality palliative care is provided irrespective of the setting. A phone interview with the project leader supported the organisation's input and commitment to the project.</p> <p>The Clinical Nurse Manager (CNM) is working with the renal unit at the DHB to improve outcomes for residents in aged care facilities receiving dialysis. This has resulted in an on-line learning package being available to assist nurses in aged care working with these residents.</p> <p>Both these initiatives are ongoing and results are not able to be evaluated at this stage.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are able to be accessed via the national interpreter service when required. Staff knew how to do so, although reported this was rarely required due to all present residents being either able to speak English or family members being available for residents whom English is not their first language.</p> <p>Staff were observed communicating effectively with residents and family. There was appropriate communication for the needs of all residents.</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>Masonic Care Limited is governed by a board of trustees who meet throughout the year. The village manager reports to the chief executive officer (CEO) monthly and the CEO presents a combined report to the board which includes a wide range of subjects including facility performance, care reporting, HDC investigations and sector issues. The village manager and CEO confirmed this. The CEO advised they have weekly contact with the village manager.</p> <p>A strategic plan 2016-2021 includes a purpose, vision, mission statement, values and operating environment. A flow chart sets out several goals for the organisation, as well as the monitoring and reporting processes against these systems.</p>

		<p>The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service.</p> <p>The facility is managed by an experienced village manager (VM) who has been in this position for eight years. The village manager is supported by a clinical nurse manager who is a registered nurse and was appointed to their current position in 2011. The CNM is responsible for oversight of clinical care.</p> <p>Review of the managers' personal files and interview of the VM and CNM evidenced they have undertaken on going education in relevant areas.</p> <p>Horowhenua Masonic Village has recently won two categories in the Kapiti-Horowhenua business awards; winner of the medium-large business 2016 and employer of choice achievement award.</p> <p>Horowhenua Masonic Village is certified to provide hospital level, and rest home level care, including 13 dual purpose beds. On the day of this audit there were 35 hospital level care residents and 35 rest home level care residents. This includes six residents under the 'Occupational Right to Occupy Agreement'. There are currently three residents with either an intellectual and/or physical disability, two of whom are under the age of 65 years and one resident is aged 65 years.</p> <p>The service has contracts with the DHB for 'Complementary Care Services' – a dedicated respite bed funded at hospital level, 'Aged care residential Care', and 'Health Recovery Beds'. A contract is also held with the Ministry of Health for an 'Outcome Agreement' for the residents with intellectual and/or physical disabilities, under the age of 65 years.</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>	FA	<p>In the absence of the village manager, the clinical nurse manager deputises with support from the administer and quality coordinator. When the CNM is absent, a charge nurse takes responsibility for clinical overview. The VM and the CNM confirmed their responsibility and authority for these roles</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	FA	<p>A quality improvement plan 2017 guides the quality programme and includes goals and objectives. An internal audit programme is in place and internal audits completed for 2016 and 2017 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. A health and safety manual</p>

<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>is available that includes relevant policies and procedures. The health and safety coordinator is responsible for hazards and demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.</p> <p>Management, infection control, health and safety, staff, unit and RN/EN meetings are held monthly and minutes were reviewed. The village manager, clinical nurse manager and quality manager stated quality data is discussed at the various meetings. Review of meeting minutes and interviews of staff confirmed this. Care staff reported that copies of meeting minutes are available for them to review in the staff areas.</p> <p>Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed. Quality improvement data included adverse event forms, internal audits, meeting minutes, satisfaction surveys and health and safety. There was documented evidence of data being collected, collated, analysed to identify trends and reported. Corrective action plans are being developed, implemented, monitored and signed off as being completed. Benchmarking is also provided by an external agency and with other facilities within the group.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. The 'Risk Management Policy' includes interRAI requirements. Policies and procedures are available with systems in place for reviewing and updating the policies and procedures. All policies and procedures were current. Staff confirmed they are advised of updated policies and that they provide appropriate guidance for the service delivery.</p> <p>Horowhenua Masonic is part of a project with the Arohanui Hospice relating to palliative care. The project is in response to the recognition by the Ministry of Health for the need to provide quality palliative care to all, regardless of diagnosis or care setting.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form that includes completed neurological observations and falls risk assessments completed following accidents/incidents as appropriate. These are collated by the quality coordinator. The original forms are kept in the residents' files. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an incident/accident policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. The satisfaction surveys confirmed this.</p>

		<p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The VM and CNM advised there have been two essential notifications (Section 31) made to the Ministry of Health and notification to the local DHB relating to an infection outbreak, since the previous audit.</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>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>On-going education is a strength of the service. The programme is the responsibility of the CNM who has developed innovative ways of encouraging staff to attend sessions. In-service education is provided for staff in several ways, including on line learning, compulsory study days and specific topics relating to residents' health status at handovers. External speakers are utilised. Staff also attend other external education. Individual records of education including current competencies are held on staff files and electronically. Attendance records are maintained and show high levels of attendance. Six RNs are interRAI trained and have current competencies.</p> <p>The CNM advised a New Zealand Qualification Authority education programme will shortly be re-introduced for staff to complete. Three staff members are assessors for the facility.</p> <p>Three senior RNs are enrolled into postgraduate studies at Massey University to become nurse prescribers. Seven of the 16 RNs have achieved achieved proficient professional development recognition programme(PDRP), four RNs have achieved at competent level and two RNs are currently completing the nursing entry to practice programme.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to six weeks to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale in place for determining service provider levels and skill mix to provide safe service delivery. Registered nurse cover is provided 24 hours, seven days a week. On call after hours is provided by the VM, CNM and charge nurses. The minimum number of staff on duty is during the night and consists of one RN and three caregivers. The RN is responsible for the whole facility and each unit has a caregiver.</p> <p>The village manager reported it is envisaged that staffing levels will not need to be increased following the reconfiguration of the three bedrooms. Review of the rosters confirmed staffing levels on the morning and afternoon shifts throughout the facility are high for both RNs and care givers.</p> <p>Care staff interviewed reported there is good staff cover and that they can get through their work. RNs and selected staff have a current first aid certificate. Residents and families reported staff provide them or their relative with a high level of care. The annual resident and family satisfaction surveys confirmed this.</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>The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with CNM. They are also provided with written information about the service and the admission process. The organisation seeks information for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'pink envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, medication documentation, progress notes and advanced directive is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed a planned and co-ordinated approach. Family of the resident reported being kept well informed during the transfer of their relative.</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>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with 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. These medications are checked by an RN 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. Controlled drugs are checked by two staff for accuracy in administration. 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 include 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 is consistently recorded on the medicine chart.</p> <p>There were two residents self-administering non-blister packed medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the CNM and recorded on an accident/incident form. The resident</p>

		<p>and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified. Evidence was sighted of a reduction in medication errors since the implementation of the electronic system.</p> <p>Standing orders are used, are current and comply with guidelines.</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 food service is provided on site by a cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been planned by a qualified dietitian, who is on site fortnightly, in May 2017.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training, provided by the dietitian.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed and overseen by the dietitian. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNM. There is a clause in the admission agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, cultural, spiritual and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents under the Aged Related Residential Care contract (ARCC) have current interRAI assessments completed by one of six trained interRAI assessors on site. The service provides on-site dietitian services to all residents requiring specialist input with nutritional advice.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>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 interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. 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>	<p>FA</p>	<p>The activities programme is provided by a trained diversional therapist, who is supported by three recreation officers.</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 as residents needs change and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered.</p>

		<p>Examples include events with other aged care facilities, outings to view the new motorway, attendance at community events and visits by community groups or entertainers. The activities programme is discussed following each event and residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. A previous request for activities to be provided over the weekends has been addressed. Residents interviewed confirmed they find the programme enjoyable.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<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/clinical reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were consistently reviewed for and progress evaluated as clinically indicated, and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, and include web-based consultations. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste,</p>	FA	<p>There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current.</p> <p>There was protective clothing and equipment in the sluice rooms and laundry that is appropriate to</p>

infectious or hazardous substances, generated during service delivery.		recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness was displayed at the entrance to the facility that expires 1 June 2018. The internal and external areas are maintained, safe and appropriate to the resident group and setting. Each unit has a sheltered courtyard with seating and shade. Residents interviewed confirmed they can move freely around the facility and that the accommodation meets their needs.</p> <p>Part of unit two is currently being reconfigured to provide one bigger bedroom with a full ensuite that will be dual purpose (accommodation for rest home or hospital level care) and two care suites under an occupational right agreement. The VM advised these rooms will be finished and occupied by the beginning of August. A certificate of public use was sighted for the re-configuration.</p> <p>There is a proactive and reactive maintenance programme and the buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by four maintenance people. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</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>	FA	<p>Bedrooms have a mix of full ensuites or ensuites with a toilet and wash hand basin. There are adequate numbers of additional bathrooms and toilets throughout the facility with engaged/vacant signage. Residents and families reported that there are sufficient toilets and they are easy to access. The reconfigured bedrooms have full ensuites.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group</p>	FA	<p>The care suites are spacious with a mix of other rooms large and some smaller. Personal space is provided for residents and staff to move safely around in all the bedrooms. Residents and families spoke positively about their or their relative's accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is adequate room in the facility to store mobility aids such as mobility scooters, wheelchairs</p>

and setting.		and walkers.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Numerous areas are provided for residents to frequent for activities, dining, relaxing and for privacy. Residents, families and staff confirmed and observation evidenced these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Bed linen and towels are contracted out to an external laundry company and all other laundry is washed on site. Residents and families reported the laundry is managed well and residents' clothes are returned in a timely manner.</p> <p>The facility is cleaned to a high standard. There are dedicated cleaners on site who have received appropriate education. The cleaners demonstrated a sound knowledge of processes. Residents and families stated the facility is always clean. The satisfaction surveys confirmed this. Chemicals are stored securely. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A letter from the NZ Fire Service dated 9 April 2013 confirmed the fire evacuation scheme remains approved and operative. There is an evacuation policy on emergency and security situations that covers all service groups at the facility. A fire drill takes place six-monthly. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted and all equipment had been checked within required timeframes.</p> <p>There is always at least one staff member on duty with a current first aid certificate.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs. Back up lighting and a generator are available should there be a power outage.</p> <p>There are call bells to alert staff. Residents and families reported staff respond promptly to call bells.</p> <p>Contractors must sign in and out of the facility. The external doors are alarmed at dusk and an</p>

		<p>external company completes checks throughout the night.</p> <p>The ORA care suites have call bells in the ensuites, bedrooms and living areas.</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>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by heat pumps, water filled heaters and underfloor heating. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from an external advisor. The IPC programme and manual are reviewed annually.</p> <p>One of three charge nurses is the designated IPC resource nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the IPC committee. This committee includes the CNM, IPC resource nurse, the health and safety officer, quality co-ordinator and representatives from food services and household management. Surveillance data is presented at staff and management meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell.</p> <p>Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of</p>	FA	<p>The IPC resource nurse has appropriate skills, knowledge and qualifications for the role, and has been in this role for eight years. She has attended relevant study days in IPC, as verified in training records sighted. The organisation has an external IPC advisor, with well-established expertise networks to guide them in any IPC related concerns. The nurse has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC resource nurse confirmed the availability of resources to support the programme and any</p>

the organisation.		outbreak of an infection.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were last reviewed in 2016 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of IPC policies and practices.</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>	FA	<p>Priorities for staff education are outlined in the IPC annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the IPC resource nurse. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when an outbreak of Norovirus occurred recently.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather and isolation strategies.</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</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this and management is documented in the residents' clinical records and on infection reporting form. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The IPC resource nurse reviews all</p>

infection control programme.		<p>reported infections. Monthly surveillance data is collated, recorded in the electronic IPC management system and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality meetings, staff meetings and at resident handovers as confirmed in meeting minutes sighted and interviews with staff.</p> <p>Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the CNM, IPC committee and quality committee. Data is benchmarked externally and within the group. Benchmarking has provided assurance that infection rates in the facility are at a rate comparable with other similar facilities. Monitoring of antibiotic use is included in surveillance analysis.</p> <p>A summary report for a recent norovirus outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the previous outbreak in 2014 had been incorporated into practice. Comparisons of the events, verify the recent event was well managed and the outbreak was well contained.</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 demonstrated that the use of restraint is actively minimised. There were nine residents using restraint and one resident using an enabler during the audit. The restraint coordinator is one of the charge nurses and demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register is current and updated. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers.</p> <p>The restraint approval group forms part of the RN/EN meetings. Restraint is also discussed at the staff meetings. Meeting minutes confirmed this.</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>A job description for the restraint coordinator was evident in the charge nurses file. Responsibilities of the restraint coordinator and approval group are clearly outlined. Restraints to be used by residents are approved by the restraint approval group prior to commencing the restraint, this includes the resident's GP. The GP completes three-monthly reviews of the restraints in use.</p> <p>Restraint use is discussed in the quality and staff meetings. Staff confirmed their knowledge of the restraint processes. The restraint coordinator provides a quarterly restraint report.</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>	<p>FA</p>	<p>Restraint assessments are completed prior to commencing any restraint. Risk factors are identified in the assessment and the purpose of the chosen restraint was documented. A care plan for restraint is developed that include objectives, goals and interventions. Long term care plans reviewed clearly documented desired outcomes. Staff demonstrated good knowledge in maintaining culturally safe practice when completing assessments for restraint use.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Safe use of restraint is actively promoted. There is a current and updated restraint/enabler register. The restraint care plans include any risk factors and ensures the resident's safety while using restraint. Staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. There are restraint minimisation policies and procedures that are accessible for all staff to read. There were no restraint-related injuries reported. There were monitoring forms for all residents who are using restraint and these were completed as required.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint and enabler use is evaluated at least three-monthly by the restraint coordinator and the resident's care plan six monthly. Consents and evaluation forms were signed by the GP and the resident's family/EPOA. The evaluation form included the effectiveness of the restraint and the risks documented in the care plans. Staff confirmed their feedback was obtained by the restraint coordinator when evaluating the restraint in use. The restraint approval group evaluated the restraints in use at RN/EN meetings. Meeting minutes confirmed this</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>	<p>FA</p>	<p>The restraint coordinator and the restraint approval group is responsible for monitoring and reviewing restraint. Restraint is also monitored through the internal audit programme. Identified issues are discussed at the management and RN/EN meetings and any corrective actions put in place. The facility has low-low beds and sensor mats in place to assist in reducing the use of restraint.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.