Bupa Care Services NZ Limited - Ascot Care House

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 Health and Disability Auditing New Zealand 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:	Bupa Care Services NZ Limited
Premises audited:	Ascot Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 26 September 2017 End date: 27 September 2017

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: 89

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ascot Care Home is part of the Bupa group. The service is certified to provide rest home, hospital (medical and geriatric), dementia and residential disability (physical) level of care for up to 104 residents. On the day of audit there were 89 residents.

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

The care home manager has been in the role for three years. She is supported by a clinical manager with 10 years aged care experience and has been in the role for the last three and a half years.

There are quality systems and processes being implemented that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Bupa quality and risk management programme that is individualised to Ascot Care Home. Quality initiatives are being implemented, which provide evidence of improved services for residents. There is an orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Ascot Care Home endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrated an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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.

Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. Ascot Care Home is implementing the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including quality meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrated a culture of quality improvements. An annual resident/relative

satisfaction survey is completed and there are regular resident/relative newsletters. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. The staffing levels meet the needs of residents. Registered nursing cover is provided 24 hours a day, seven days a week.

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.

There is an admission package available prior to or on entry to the service. Resident records reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six-monthly. Resident files include three-monthly reviews by a general practitioner. There is evidence of other allied health professional input into resident care. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three-monthly by the general practitioner/nurse practitioner. An activities programme is implemented separately for the rest home, hospital and dementia residents. The programme includes community visitors and outings, entertainment and activities that meets the recreational preferences and abilities of the residents. All food and baking is done on-site. All residents' nutritional needs are identified and documented. Choices are available and are provided. The organisational dietitian reviews the Bupa menu plans. Nutritious snacks are available in the kitchen for all units.

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.

Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Some have shared and own ensuites. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe, secure and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Hot water temperatures are monitored.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place. At the time of the audit, the service had three residents using restraints (lap belts) and no residents with an enabler. Staff receive training in restraint minimisation and management of challenging behaviours. Assessed risks are documented in care plans. Ongoing restraint assessments, monitoring and evaluation occurs. The service and organisation regularly review restraint use and strive to minimise the use of restraint.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with 16 care staff (seven caregivers, three registered nurses (RN), one-unit coordinator, three enrolled nurses (EN) and two diversional therapists), reflected their understanding of the key principles of the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	There is an informed consent policy. In all ten files sampled, four rest home (one of which is respite), three dementia and three hospital (including one YPD) all had general consent forms signed and consent for van outings on file. Consent forms were signed and on file for flu vaccinations. Staff were knowledgeable around informed consent. Overall residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy. The Bupa care services resuscitation of residents' policy states 'if resuscitation is clinically indicated, and the resident is competent, he or she may wish to make an advance directive as to resuscitation wishes'. The medical resuscitation treatment plan and resuscitation advance directive are completed as soon as possible after admission. There is evidence of family/EPOA discussion with the GP for a medically indicated

consent.		not for resuscitation status. In the files sampled, there is an appropriately signed resuscitation plan and advance directive in place. Discussions with residents and relatives demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been signed and sighted for all the files seen.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident and relative meetings are separate and are held every four months. Quarterly newsletters are provided to residents and relatives.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint's register. Fifteen complaints made in 2016 and seven complaints received in 2017 year-to-date were reviewed with evidence of appropriate follow-up actions taken. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). Any corrective actions developed has been followed-up and implemented. One complaint made through the HDC in 2016 was investigated and followed up, with an HDC letter in June 2016 that the complaint was closed off and no further action would be taken. Another complaint made through the HDC in 2015 is still ongoing with the service awaiting a response from HDC to a follow-up letter in November 2016. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, clinical manager and RNs discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Twelve residents (eight rest home and four hospital level) and five relatives (one rest home, one hospital and three dementia care) interviewed, reported that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. Staff received training on abuse and neglect in July 2017.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit there were four residents that identified as Māori living at the facility. Māori consultation is available through the documented iwi links (Te Koru Wai) and Māori staff who are employed by the service. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. Cultural awareness and treaty of Waitangi training was completed by staff in July 2017.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their	FA	The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. There is a total of 47 general practitioners (GP) listed, at the time of the audit the service was finalising the possibility of having one main practise GP service. The service receives support from the district health board (DHB). Physiotherapy services are provided on-site, six and a half hours per week. There is a regular in-service education and training programme for staff. A podiatrist is on-site for eight hours per week. The service has links with the local community and encourages residents to remain independent. Bupa has established benchmarking groups for rest home, hospital, dementia, psychogeriatric/mental health services. Ascot Care Home is benchmarked against the rest home, dementia and hospital data. If the results are above the benchmark, a corrective action plan is developed by the service. All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. The Bupa quality and risk team provides a bi-monthly clinical newsletter called Bupa Nurse which provides a forum to explore clinical issues, ask questions, share experiences and updates with all qualified nurses in the company. The Bupa geriatrician provides newsletters to GPs. There is a dementia-specialist employed by Bupa to support staff within the organisation with training and residents with behaviours that challenge.
Standard 1.1.9: Communication Service providers communicate effectively with	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or

consumers and provide an environment conducive to effective communication.		not) of an accident/incident. Fourteen accident/incident forms reviewed across the service identified that family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. An introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility. This booklet is included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ascot Care Home currently provides rest home, hospital - medical/geriatric and dementia care for up to 104 residents. There are 40 rest home beds, 40 hospital level beds and 24 dementia care beds. On the day of audit there were 89 residents including 39 rest home (including two residents on respite care); 30 hospital level (including three residents on long-term support chronic health conditions (LTSCHC) contracts) and 20 dementia level of care. All other residents were under the aged related residential care (ARRC) contract. A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. Ascot Care Home is part of the Southern Bupa region and the managers from this region meet bi-monthly to review and discuss the organisational goals and their progress towards these. The operations manager teleconferences monthly and completes a report to the director of care homes and rehabilitation. Ascot Care Home has set a number of quality goals that link to the organisations quality and health and safety goals. Quality goals include (but not limited to); (i) to reduce falls from last year by 10%, In 2016, this goal was achieved with an overall reduction in facility the of 26%. The service has continued the goal in 2017. A quarterly report is prepared by the care home manager and sent to the Bupa continuous service improvements (CSI) team on the progress and actions that have been taken to achieve the Ascot Care Home quality goals. The care home manager is a RN who has been in the role for three years and has previous nursing management experience within the district health board (DHB) environment. She is supported by a clinical manager with 10 years aged care experience and who has been in the role at Ascot Care Home for the last three and a half years. The management team are supported by a team of nurses, an operations manager and a director of nursing. The operations manager was present during the audit. The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service including dementia level care.

Standard 1.2.2: Service Management 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.	FA	The clinical manager who is employed full time steps in when the care home manager is absent. The operations manager who visits regularly, supports the clinical manager.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Ascot Care Home has a quality and risk management system that supports the provision of clinical care and support. Bupa has systematically been rolling out an electronic incident reporting system (Riskman) throughout the care homes. By the end of October 2017 Riskman will be implemented in all the care homes nationally. Quality and risk data results are discussed in the quality/staff meetings. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are established, implemented and are signed off when completed. There was an annual resident/relative satisfaction survey completed in June 2017. A corrective action plan was implemented following feedback received from the 2016 resident/relative satisfaction survey feedback where the overall satisfaction rate was 93%. Results for the annual resident/relative satisfaction survey completed in 2017 had not been finalised. Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. An employee health and safety programme (Smile) is in place, which is linked to the overarching Bupa National Health and Safety Plan. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by	FA	Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Fourteen accident/incident forms were reviewed for September 2017. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observations were completed for unwitnessed resident falls reviewed that resulted in a potential

the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		head injury. Incidents are benchmarked and analysed for trends. The care home manager and clinical manager were able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. The service has reported twelve category one events (since the last audit) to Bupa head office and to the relevant authorities, relating to a power failure, coroner's inquest, four resident absconding's (link 1.4.7) and six pressure injuries (all sighted).
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources policies include recruitment, selection, orientation and staff training and development. Eleven staff files (one clinical manager, two unit-coordinators, two RNs, three caregivers, one activities coordinator, one laundry person and one cook) reviewed, evidenced implementation of the recruitment process, employment contracts and completed orientation checklists. Staff performance appraisals were all completed and signed off on an annual basis. A register of registered nursing staff and other health practitioner practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g., RN, support staff) and includes documented competencies. The caregivers when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, care staff have effectively attained their first national certificates. From this, they are then able to continue with core competencies level-three, unit standards. These align with Bupa policy and procedures. Thirty-four percent of the total of caregivers have attained a Careerforce qualification. A total of 94% of staff have attained at least one Bupa Personal Best certificate. There are 12 caregivers who work in the dementia unit and five have completed the required dementia standards. Four caregivers are in the process of completing their qualification. The three caregivers that have not completed have commenced work within the last six months. There is an annual education and training schedule being implemented. Opportunistic education is provided via toolbox talks. Education and training for clinical staff is linked to external education provided by the DHB. There are 15 RNs in total and eight have completed interRAI training, with two RNs currently being trained. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). There are a number of implemented competencies for RNs including insulin administration, moving & handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, syringe driver and medication competencies. The service implemented a quality initiative around increasing staff buy-in to education and to increase staff attendance. The initiative included changing education sessions from 2-8-hour workshops to a full 8-hour day workshop repeated over an entire week. The outcome was 84 staff educated over the course of the

		week. Staff evaluation identified this was positive.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. Ascot Care Home has a four-weekly roster in place which ensures there are adequate staffing levels to meet the acuity and safety needs of the residents. Interviews with residents and family members identified that staffing is adequate to meet the needs of residents. The care home manager and clinical manager work fulltime and are available during weekdays. The care home manager and the clinical manager share the on-call duties. Adequate RN cover is provided 24 hours a day, seven days a week. In the hospital (30 of 40 hospital residents), there is one unit-coordinator on duty from 7.30am to 4.30pm and one RN on the morning and afternoon, and night shifts. There are five caregivers on duty on the morning and afternoon shifts and two caregivers on the night shift. In the rest home (39 of 40 rest home residents) there is one unit-coordinator on duty from 8.30am to 1.00pm and one RN on the morning shift and one EN on the afternoon shift. There are four caregivers on duty on the morning and afternoon shifts, and two caregivers on the night shift. In the dementia care unit (20 of 24 dementia residents) there is one RN/EN on the morning and afternoon shifts. There are two caregivers on duty on the morning and afternoon shifts, and one caregiver on the night shift.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has	FA	There is a comprehensive admission policy. Residents are assessed prior to entry to the service by the needs assessment team. Specific information is available for residents/families/whānau at entry. Admission agreements align with the ARC contract, exclusions from the service were included in the admission agreement. The information pack includes all relevant aspects of the service and residents and/or family/whānau are provided with associated information such as the Code, how to access advocacy and the health practitioners code. All relatives interviewed were familiar with the contents of the pack. An enquiry pack is available for potential residents. There is a short-stay admission agreement for respite admissions. The care home manager and clinical manager screen admissions prior to entry to ensure a needs

been identified.		assessment has been completed and the service is able to provide the level of care required, if there is a room available. The admission procedure is detailed. An admission agreement is signed either by the resident or EPOA, consent forms are discussed and signed, and an admission booklet is completed. All information gathered is kept in the residents file. Of the ten resident files sampled, all had signed admission agreements and consent forms. All relatives interviewed feel they were fully informed of service provision and how to access services not included. All relatives felt they could refer to their admission pack. The admission policy and resident information handbook outlines access, assessment and the entry screening processes. The local community and needs assessment and coordination agencies are familiar with entry criteria and how to access the service. The service operates 24 hours a day, 7 days a week. Comprehensive information about the service is made available to referrers, potential residents and their families and sighted resident agreements contain all detail required under the Aged Residential Care Agreement. Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. EPOA's were on resident files.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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. A transfer form accompanies residents to receiving facilities and communication with family is made.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room/cupboards. There was evidence of three-monthly reviews by the GP. Registered nurses, enrolled nurses and caregivers administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Temperature monitoring of the medication fridges were recorded daily and all within range. There was one resident self-administering medication on the day of audit. Fully completed competency was on file, and reviewed three-monthly. There are no standing orders. Oxygen is prescribed on the electronic system. For residents on continuous oxygen, this is prescribed as continuous, residents oxygen saturations are checked routinely at least once a shift. For residents prescribed 'as required' oxygen, this is prescribed to be administered when oxygen saturations are below a certain level. One resident is prescribed oxygen by the respiratory consultant to be administered 16 hours per day. The resident has chosen for this to happen overnight. This is prescribed to be administered once a

		day at night with no time specified. There is no time specified on any of the oxygen prescriptions. 'As required' oxygen is in situ until oxygen saturations reach 'normal' levels for each resident.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a head cook who oversees food management. The food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and there is a national menu in place that has been audited and approved by an external dietitian. There are policies in place to guide staff. All food is cooked on-site in a large commercial kitchen. There is sufficient storage available. Stock rotation is practised. Hot food temperatures are monitored daily on all meals (records sighted). Fridges and freezers have temperatures monitored daily. Chilled inward goods are temperature checked on delivery and prior to storage. Daily air temperatures are recorded. Resident likes, and dislikes are known, recorded in the kitchen and alternatives are offered. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes and is reviewed six-monthly, as part of the care plan review. Special diets (i.e., soft and pureed diets) are noted on the kitchen noticeboard, which can be viewed only by kitchen staff. Meals are served from hot trolleys to the residents in the dining rooms and can be delivered to rooms as required. Specialist utensils and plates are available for residents. The resident annual satisfaction survey monitors food satisfaction. The kitchen is included in the internal audit programme. Staff have been trained in safe food handling and chemical safety. Residents and relatives interviewed commented positively on the meals provided. There are snacks available 24/7 in the dementia unit for residents. As part of quality initiatives, the service introduced a self-serve breakfast in the rest home area, to increase quality of life, community and weight management, this has proved popular and well received. They have also created a self-serve saucy horse café for families and residents to use as social destination this is very well used and popular
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	There is policy in place regarding the process for declining entry. Consumers are declined entry when there are no beds available or, if the person has health needs that are not able to be provided by the facility. If a potential admission was declined entry, the consumer and where appropriate their family/whānau of choice, is informed of the reason for the decline and provided with other options where they can access services.

Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Comprehensive Bupa admission booklets which include risk assessments have been completed on admission in all files sampled. InterRAI initial and subsequent assessments have been completed, and printed copy of assessment summaries are evident in eight out of ten files (one recent admission, and one pending admission). Files reviewed in rest home, hospital, and dementia areas all had risk assessments completed on admission and reviewed six-monthly. Assessments such as wound, pain, behaviours and restraint were fully completed as resident need indicated. Information gathered from assessments is integrated in care plans in all ten files sampled.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed were comprehensive and included input from allied health as required. In all ten files, reviewed all care plans were individualised to resident need. Specific care plans are included and are reflective of resident need. Nurse's complete transfer plans for residents with no mobility issues, otherwise these are completed by physiotherapist. Short-term care plans are in place for acute episodes of care, and resolved or transferred to long-term care plans in a timely manner. There is evidence of allied health input to care in care plans. Relatives interviewed were happy with the standard of care provided. Short-term care plans were in use for changes in health status and signed-off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care professionals.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Nurses and care staff follow the care plan and report against progress at each handover. Referrals to nurse specialists, dietitian and the like are discussed with the GP then activated by the RN. Medical referrals are actioned by the GP. There are adequate supplies of dressings and continence supplies available in all areas. Specialist continence advice is available if required. Wound assessments, management plans and evaluations were all fully completed. On the day of the audit, there were eight wounds in the hospital unit (three vascular ulcers, one scratched area one skin tear, one abrasion of fragile skin, one friction ulcer and one excoriated area). Three wounds in rest home area (two skin tears and one abrasion), and seven wounds in the dementia unit (six skin tears and one laceration) eighteen wounds in total. Incident forms and neurological vital signs were fully completed in six unwitnessed falls. Monitoring charts sighted included bowel monitoring, weight, vital signs, food and fluid, behaviours, restraint and turning charts. Interviews with RNs and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted included behaviour charts, restraint monitoring forms, turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. Dietitian was involved and residents were on protein supplements.

Standard 1.3.7: Planned Activities 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.	FA	The activities team at Ascot Care Home is comprised of three diversional therapists and two activities coordinators who offer activities for residents seven days a week. One diversional therapist has completed the 'spark of life' training and works predominantly in the dementia unit. The activity team have access to the Bupa diversional therapy (DT) team at head office and attend the regional DT/activities regional study days with training and education including guest speakers. Each resident has an individual activities programme, which is reviewed when their plan of care is reviewed and as part of their interRAI assessments. The activity programme is implemented over seven days per week in all three areas. There are large open plan central lounge/dining areas which are used for activities for rest home and hospital. There are ranges of activities offered. There are separate rest home/hospital and dementia programmes with activities that meet the needs and preferences of the resident groups; however, some activities are integrated such as entertainment, as observed on the day of audit. Activities are provided in the dementia unit between 10.30 - 12,1.30 -4.30 then 6.30-8.30pm (7 days a week). Variations to the group programme are made known to the residents. Residents may choose to participate in any group programme. Individual programmes are delivered to residents in their rooms when they are unable to or choose not to participate in the group programme. Evening activities are offered in the dementia unit. The group programme covers physical, cognitive, social and spiritual needs. There are regular visiting entertainers and community groups. Targeted group programmes are offered as appropriate to meet the needs of subsets of residents. A weekly rotation of local churches come to provide church services. Residents can go on outings using the service's van, there is a local community van suitable for residents in wheelchairs which is utilised. Some rest home residents choose to use alternative transport arrangements to attend community interests. Residents have the opportunity to provide feedback on the activity programme through the bi-monthly resident meeting and resident satisfaction surveys. Residents and relatives interviewed were satisfied with the activities programmes on offer. As a result of concerns raised by families around the activities in dementia unit, they we have increased activity hours with the increase in resident's numbers.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurs. Written evaluations reviewed described the resident's progress against the residents identified goals. Short-term care plans for short-term needs are evaluated and either resolved or added to the long-term care plan as an ongoing need. The six-monthly multidisciplinary review involves the RN, GP, activities staff, physiotherapist (if involved) and resident/family. The family are notified of the outcome of the review by phone call and if unable to attend, they receive a copy of the reviewed plans. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	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. There was evidence of where a resident's condition had changed, and the resident was reassessed for a higher or different level of care. Discussion with the clinical manager, RNs and ENs identified that the service has access to a wide range of support either through the GP, Bupa specialists or contracted allied services.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There is an effective system of waste management in place. Chemicals are supplied by an external contractor and stored securely throughout the facility when not in use. Appropriate policies are available along with chemical product safety charts. Education on hazardous substances occurs at orientation and is included in in-service training. There is appropriate signage throughout regarding chemical storage and hazards. There is personal protective equipment available for use by staff and this was in use on the day of audit.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness, which expires January 2018. The facility employs a full-time maintenance manager. There are proactive and reactive maintenance management plans in place. The grounds and gardens are maintained by a qualified gardener who assists with maintenance. Contracted providers test equipment. Electrical testing of non-hard-wired equipment was last conducted in August 2017. Medical equipment requiring servicing and calibration was last conducted in August 2017. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors to the facility. Residents have adequate internal space to meet their needs. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents are designated drivers. Since the previous audit the following environment improvements have been made; (i) Outside furniture has been purchase for the residents and families to use in the rest home area. (ii) A pergola has been installed in

		the rest home area outside to provide a shaded area for residents and visitors to use; and a fish tank has been hired for residents to view and care for and as an activity in the hospital Grebe wing. There are safe and secure garden areas in the dementia unit with seating and shade provided, the service is in the process of creating a “loop” walkway for residents (link 1.4.7).
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are adequate toilets and showers for residents. Some rooms have a shared ensuite. Some rooms are ensuite. Separate visitor and staff toilet facilities are available. Water temperatures are monitored, and temperatures are maintained at or below 45 degrees Celsius. Fixtures fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Resident rooms are spacious. Walking frames, wheelchairs and hoists can be manoeuvred around the bed within the rooms, if required. Residents requiring transportation between rooms or services can be moved from their room either by trolley or by wheelchair.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and	FA	There are several lounges throughout the facility and combined lounge/dining rooms. Residents can move freely. Activities occur mainly in the large rest home and hospital combined living/dining areas. There are quiet areas if people wish to speak privately. There is a café in the rest home lounge, so residents and relatives can make their own beverages. Activities in the dementia unit occur in the lounge.

dining needs.		
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	A team of household staff managed by the full-time household supervisor cleans the facility. The household staff have access to the appropriate equipment and chemicals. Cleaning equipment and cleaning chemicals are stored securely when not in use. Laundry services are completed on-site. Internal audits are completed to monitor performance. Household staff receive training at orientation and through the in-service programme. There are policies in place to guide practice. The service has introduced a number of quality improvements as a result of resident and family feedback including (but not limited to); (i) specialised odour control machines have been purchased for the control of strong odours from wounds and end-of-life residents. (ii) A commercial carpet cleaning machine has been purchased for the purpose of keeping odour down especially in the dementia unit, this has had a very positive effect on the environment. (iii) Steamer machines have been bought for effective cleaning of lazy boys and kitchen areas. Residents and relatives interviewed confirmed they were happy with cleaning and laundry.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. Fire evacuation drills take place every six months, with the last fire drill occurring on 6 September 2017. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities (two BBQs) for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup. Emergency food supplies sufficient for three days are kept in the kitchen. Pandemic/outbreak supplies are available. There is sufficient water stored to ensure for three litres per day for three days per resident. There are civil defence emergency/disaster wheelie bins on each level of the building. There are also first aid kits, located in the kitchen, maintenance area, at reception and at the nurse's stations. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. Access by public is limited to the main entrance. The facility is secured at night. There is an implemented corrective action plan in place around increasing the security of the dementia external garden. After two category one incidents of resident's absconding from the unit in August and September 2017. The Bupa property team completed an assessment and the areas of greater risk were addressed. This including changing the posts on either side of the external gate to prevent flexing and replaced the lock. Further design changes are in the process of being implemented as part of the corrective action including (but not limited to) (i) removing the path that leads to gate and extending the pathway around the building, (ii) planting a garden underneath the fence with shrubbery that grows upwards which

		would distract residents from the fence; (iii) replacing the west gate into the carpark and replacing the fence wither side with higher panels. During the audit the DHB were on-site assessing the changes made by Bupa in regards to the security of the dementia unit.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The facility is light and airy and able to be ventilated by opening external windows and doors. There is overhead electric heating. Internal temperatures are monitored and regulated by the maintenance manager. Residents interviewed were happy with the temperature.
Standard 3.1: Infection control management 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.	FA	The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control coordinator is the clinical manager and she is responsible for infection control across the facility. The committee and the Bupa governing body in conjunction with Bug Control, is responsible for the development of the infection control programme and its review. A lower north/southern regional infection control meeting addresses infection control issues across the organisation. The infection control programme is well established at Ascot Care Home. The quality/infection control committee consists of a cross-section of staff and there is external input as required from general practitioners, and local community laboratory. There is good access to public health service and hospital resource staff. The infection control nurse has attended external education by the DHB.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme at Ascot Care Home. The infection control (IC) coordinator has maintained best practice by attending infection control updates. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. The IC coordinator has a ‘glow bug kit’ and regularly performs spot handwashing checks.

Standard 3.3: Policies and procedures 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.	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control committee, training and education of staff and scope of the programme.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions. Infection control training was last provided in April 2017. The infection control officer has received education by the Southern DHB, and Bupa education sessions to enhance her skills and knowledge. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice and group benchmarking. A number of toolbox talks have been provided, including (but not limited to) over treating urinary tract infections and the importance of hand hygiene.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and local laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control officer. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. At the time of the audit, the service had three residents using restraints (lap belts) and no residents with an enabler. Staff training around restraint minimisation and management of challenging behaviours was last completed in June 2017.
Standard 2.2.1: Restraint approval and processes 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.	FA	Only staff that have completed a competency assessment are permitted to apply restraints. Competency assessments expire annually and are renewed by the restraint coordinator. There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisation level and a service level. The restraint coordinator is a RN and has a signed job description, and understands the role and her accountabilities.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. An RN is the restraint coordinator. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There was a restraint assessment tool completed for the one hospital resident file reviewed requiring bedrails for safety. The care plan was up-to-date and provides the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau was also identified. Falls risk assessments have been completed six-monthly and interRAI assessment identified risk and need for restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. The three resident files reviewed refers to specific

		interventions or strategies to try (as appropriate) before use of restraint. The care plan reviewed of one hospital resident with restraint, identified observations and monitoring. Restraint use is reviewed through the three-monthly assessment evaluation, monthly restraint meetings and six-monthly multidisciplinary meeting and includes family/whānau input. A restraint register is in place, which has been completed for the three residents requiring restraint.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred three-monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of their care plan review. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the Regional Restraint Approval group and information is disseminated throughout the organisation.

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, these 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.