

# Munro Resthomes Limited - Malyon House

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## 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:

<b>Legal entity:</b>	Munro Resthomes Limited	
<b>Premises audited:</b>	Malyon House	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 1 February 2018	End date: 2 February 2018
<b>Proposed changes to current services (if any):</b>	No	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	55	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Malyon House provides rest home and hospital level care for up to 57 residents and on the day of the audit there were 55 residents. The service is managed by a facility manager and a clinical manager. The residents and relatives interviewed spoke positively about the care and support provided.

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

This audit identified that improvements are required around wound documentation. The service has exceeded the standard related to restraint minimisation.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The staff at Malyon House ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with families identified that they are fully informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process. Communication with families is recorded. Complaints processes are implemented and managed in line with the Code.

## 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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Malyon House is implementing a quality and risk management system that supports the provision of clinical care. A facility manager and clinical manager are responsible for the day-to-day operations of the facility. Quality management processes are reflected in the businesses plan's goals, objectives and policies. Quality data is collated and discussed at staff meetings. There is a 2018-2019 business plan in place. Staff document incidents and accidents. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nurse is responsible for each stage of service provision. The assessments, initial and long-term nursing care plans are developed in consultation with the resident/family/whānau. The residents' each have a care plan, and these are reviewed at least six-monthly or earlier if there is a change in health status. The activity programme is developed to promote resident independence and social interaction. Residents interviewed spoke positively about the activity programme. Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies and medications are stored appropriately. Food services and meals are prepared on-site. There has been a dietitian review of the menu. All kitchen staff have been trained in food safety and hygiene.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with hand basins and toilets & several bedrooms included shower ensuites. There was sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas were easily accessible. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site. Hot

water temperatures have been checked and recorded regularly. A civil defence/emergency plan is documented for the service. There is a staff member on duty at all times with a current first aid certificate.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents using restraints and one resident with an enabler.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse has attended external education and coordinates education and training for staff. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Infection prevention and control is integrated into full staff and registered nurse meetings. There is a suite of infection control policies and guidelines to

support practice. A monthly infection control report is completed for analysis and benchmarked with other facilities within the Cavell group.

## 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	1	44	0	1	0	0	0
Criteria	1	92	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with eight care staff (two registered nurses (RN), five caregivers and one diversional therapist) confirmed their familiarity with the Code. Five residents (three hospital and two rest home) and four family members (one hospital and three rest home) interviewed confirmed the services being provided are in line with 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 are established informed consent policies/procedures and advanced directives. Systems are in place to ensure residents and where appropriate, their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers and RNs interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. General consents were obtained on admission and sighted in eight resident files reviewed (including one resident on younger persons with disabilities contract and one resident on respite). Advance directives were sighted in each resident's file relating to resuscitation status, having been completed by the resident (where they were competent to do



consent.		so) in the presence of the general practitioner. Policy dictates that where a resident is not competent to make an advance direction around resuscitation, resuscitation will be provided.
<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	Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service reception area. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members that were interviewed were aware of how to access advocacy services.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The service has a complaints policy that describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and family members confirmed that they understand the complaints process. They also confirmed that management and staff are approachable and readily available if they have a concern. Three complaints have been made since the last audit. All complaints reviewed have been signed off as resolved. A review of the complaints register evidences that the appropriate actions have been taken and the complainant received documented outcome of the complaint.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The Code and advocacy pamphlets are located at the main entrance of the service. On admission the RN discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. Abuse and neglect training is part of the annual compulsory training schedule.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has guidelines for the provision of culturally safe services for Māori residents. There is a Māori health plan. On the day of the audit there was one resident that identified as Māori. Interview with the Māori resident informed her cultural needs are met. Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety. The service has established links with a Māori kaumātua (NASC assessor) who assists in reviewing policies and protocol and is available for advice at any time.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Family members reported that they feel they are consulted and kept informed and family involvement is encouraged. Cultural awareness training is part of the annual compulsory training schedule.</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>The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries.</p>

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service meets the individualised needs of residents with needs relating to rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. The assistant manager is responsible for coordinating the internal audit programme. Monthly staff meetings and bi-monthly residents meetings are conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed stated that they feel supported by the management team and the RNs.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Information is provided in formats suitable for the resident and their family. Five residents and four relatives interviewed confirmed on interview that the staff and management are approachable and available. Twelve incident forms reviewed identified family were notified following a resident incident. Relatives interviewed confirm they are notified of any incidents/accidents. Families are invited to attend the bi-monthly resident/family meetings. Interpreter services are available as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Malyon House is owned and operated by Munro Resthomes Limited. The service provides rest home, hospital and long-term chronic level care for up to 57 residents. Eight beds in one wing are rest home level care only and the remaining forty-nine are dual purpose beds. On the day of audit, there were 55 residents (19 residents receiving rest home level care, including one respite resident and 36 receiving hospital level care including one younger person with disability (YPD) contract and one resident on palliative care). All other residents were under the Aged-Related Residential Care (ARRC) contract.</p> <p>Malyon House has a 2018-2019 business/strategic plan, philosophy of care and mission statement which links to the organisation's strategic plan and is reviewed monthly with the directors. The facility manager reports to the managing director regularly on a variety of operational issues.</p> <p>At the time of the audit, there was an acting facility manager who has been in the role since July 2017. She is supported by a clinical manager who has been in the position for six months. The acting facility manager was leaving on the last day of the audit, along with the managing director who was retiring. A new managing director/RN started in the role on the last day of the audit. She is also the acting facility manager until the new facility manager starts in late February 2018. A section 31 notification was completed for the facility manager and clinical manager role changes.</p> <p>The facility manager at the time of the audit had completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months.</p>

<p><b>Standard 1.2.2: Service Management</b></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>The acting facility manager reported that in the event of her temporary absence, the managing director fills the role with support from the clinical manager.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Quality and risk management systems are in place. Interviews with care staff (five caregivers working across the rest home and hospital, two RNs and one diversional therapist) confirmed their understanding of the quality and risk management programmes. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. A document control system to manage policies and procedures is in place.</p> <p>The quality and risk management programmes include an internal audit programme and data collection, analysis and review of adverse events including accidents, incidents, infections, wounds and pressure injuries.</p> <p>A corrective action process is implemented where opportunities for improvements are identified. There is evidence of results being communicated regularly to care staff in meeting minutes and on staff noticeboard. The health and safety programme includes policies to guide practice. Staff accidents and incidents and identified hazards are monitored. One of the directors is the health and safety officer and has completed the specific health and safety training required. There is a health and safety/workwell leadership team monthly meeting with a focus on promoting safe work habits amongst employees. Health and safety is also discussed at the staff and management meetings. Falls prevention strategies are in place including the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective actions. The service collects a set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident</p>

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.		information. The data is trended and linked to the quality management systems. A monthly incident accident report is completed which includes an analysis of data collected. Staff meeting minutes review the analysis of incident and accident data and corrective actions. Twelve accident/incident forms sampled from January 2018 included RN assessment following an incident.
<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>	FA	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioners practising certificates including general practitioner (GP), pharmacist and physiotherapist. Nine staff files were reviewed (one clinical manager, one maintenance person, one cook, one diversional therapist, two RNs and three caregivers). Evidence of signed employment contracts, job descriptions, orientation and training were sighted. Annual performance appraisals for staff are conducted for all employees.</p> <p>Newly appointed staff complete an orientation that is specific to their job duties. Interviews with caregivers described the orientation programme that includes a period of supervision. The service has a training policy and a scheduled in-service education planner. The in-service schedule is implemented and attendance is recorded. There is a monthly full staff training day to ensure all staff go through the compulsory annual training. There are implemented competencies for RNs including (but not limited to): medication, restraint and the use of a syringe driver. There are five of 11 RNs interRAI trained.</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>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. The facility manager and clinical manager both work full-time from Monday to Friday and share the 24/7 on call duties. Extra staff can be called on for increased resident requirements. Interviews with staff, residents and relatives confirm that there are sufficient staff on duty. The facility is split into the ground floor (Ruby, Sapphire, Jade and Topaz wings) and upstairs (Opal and Amber wings).</p> <p>On the ground floor there is a total of 35 residents (21 hospital and 14 rest home residents). There is one RN on duty in the morning shift and afternoon shift, and one on the night shift. The RNs are supported by adequate number of caregivers. There are five caregivers on the morning shift, four caregivers on the afternoon shift and one caregiver on the night shift.</p> <p>Upstairs there are 20 residents in total (4 rest home and 16 hospital). There is one RN on duty in the morning shift and afternoon shift, and one on the night shift. There are three caregivers on the morning shift, three caregivers on the afternoon shift and one caregiver on the night shift. There are two additional</p>

		floating caregivers on the morning and afternoon shifts to help out where required.
<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>	FA	The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	There are policies and procedures to safely guide service provision and entry to services including an admission policy. Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The admission agreement reviewed aligns with the services contracts for long-term and short-term care.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service. Malyon House uses the yellow envelope system for transfer to and from the DHB. The family are informed of any transfers. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.
Standard 1.3.12: Medicine Management	FA	Sixteen medication charts were reviewed (eight hospital including one palliative, and eight rest home including one YPD and one self-medicating resident). There are policies and procedures in place for safe

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>medicine management that meet legislative requirements. Medicine management complies with medication guidelines. Each resident's allergies are established during admission assessment and documented in the electronic medication administration chart. Any allergies or sensitivities are clearly noted on the medication administration chart. If no allergies are known, then this is documented to identify that it has been checked. The supplying pharmacy deliver the medication robotic packs monthly or earlier if required. All medications are checked on delivery by the RN against the medication chart (documented within 1Chart) and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses who administer medications have been assessed for competency on an annual basis.</p> <p>Education around safe medication administration has been provided. RNs attend syringe driver education. Medications were stored safely in both units. The medication fridges are checked weekly and corrective actions are taken when temperatures are outside of the acceptable range. All medications in trolleys are within the expiry date and eye drops dated on opening. The RNs in all areas were observed during the lunchtime medicines round and correct procedures are followed. The service uses standing orders which are documented for each GP and had been reviewed six-monthly by the service with each GP. The standing orders are up-to-date and comply with legislative requirements. Where medications were administered as per a standing order, this was documented on a paper non-packed/PRN signing sheet. The main medication room (downstairs) held imprest medication for the facility. Controlled drugs were stored within a locked cupboard in the locked medication treatment room.</p> <p>Medications for administration upstairs were held within the locked medication trolley, stored in the locked nurses' station. There is evidence of weekly stocktakes of controlled drugs and six-monthly physical and quantity stocktakes completed. There were three self-medicating residents in the upstairs wing unit on the day of audit. All self-medicating residents had competencies checked and signed three-monthly by the GP and medications were kept securely within the resident's room. Monitoring of self-medication for these residents was carried out weekly. The effectiveness of 'as required' medications is entered into the electronic medication system. Medication charts sampled were reviewed three-monthly by the attending GP. Oxygen cylinders, oxygen concentrators and emergency equipment are checked weekly. The use of 'as required' (PRN) medications are monitored and electronically signed with times administered, the purpose of administration and outcome.</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</p>	<p>FA</p>	<p>All baking and meals are cooked on-site at Malyon House by one of two cooks. The kitchen is spacious and includes areas for food preparation, cooking, baking, serving and cleaning areas. There are two chillers and a walk-in freezer. There is a team of kitchen staff including two cooks and four kitchen assistants. Both cooks and all kitchen assistants have completed food handling through orientation and via external national programmes. The summer and winter menus are reviewed two-yearly by an external consultant dietitian. There is access to a community dietitian. Food is transported to the kitchenette within in each wing in bain maries and is plated in the kitchenette and delivered to residents. Cooked/served</p>

component of service delivery.		<p>food temperatures are completed prior to transport and completed before serving as part of the internal audit programme (records sighted). Kitchen fridge/freezer temperatures and food temperatures are monitored at least daily. Corrective actions for temperatures outside of range are documented and re-tested. Food stored in the fridge and chillers is covered and dated. There are designated shelves within the chiller for dairy, meat and vegetable/grocery items.</p> <p>Dry goods are stored in dated sealed containers in the pantry and kept off the ground. Chemicals are stored safely. Cleaning schedules were sighted and maintained. The service has a food plan registered with MPI (September 2017) and is awaiting a site audit before their grade can be confirmed. Malyon House has an organisational process whereby all residents have a nutritional profile completed on admission, a copy of which is provided to the Cook who is also notified (daily where necessary) of any dietary changes, weight loss or other dietary requirements. There are two choices for the lunch meal and two choices at night. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. There are lists maintained within the kitchen of the resident's key alerts regarding allergies or food dislikes/preference for staff reference. Special equipment such as 'lipped plates' and built-up spoons are available as required. Residents/relatives spoken to generally spoke positively about the food provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Admission documentation includes information obtained on interview with resident/relative or advocate, from medical discharge summaries and from needs assessors. The RNs complete an initial assessment on admission, including risk assessment tools such as Coombes (falls risk) assessment, Waterlow (pressure risk) and nutrition assessments as appropriate. The facility has embedded the interRAI assessment protocols within its current documentation. The initial assessment, short and long-term care plan templates were completed in all eight resident files reviewed.</p> <p>InterRAI assessments including assessment summary, MDS comments and client summary reports were evident in printed format in all files. An interRAI reassessment has been completed where health changes</p>



		for residents have occurred. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the long-term care plan. In all eight resident files reviewed (three rest home and five hospital), assessments were conducted within the required timeframes.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Three rest home and five hospital files reviewed included an initial assessment and (initial) short-term care plan. Long-term care plans were in place for all eight residents. Short-term care plans were available for use to document any changes in health needs. Short-term care plans were evidenced for pressure injuries, skin tears, short course antibiotics and weight loss. Residents' long-term care plans reviewed were resident-focused and individualised. Relatives and residents interviewed, confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative and staff input into the development of care plans. Care plans are reviewed six-monthly.</p> <p>Short-term care plans were evaluated at regular intervals and either resolved or added to the long-term care plan if an ongoing problem. Medical GP notes and allied health professional progress notes were evident in the eight residents integrated files sampled. Relatives interviewed were very positive and complimentary about the staff, clinical and medical care provided and confirmed they are kept informed of any significant events and changes in health status. Family contact forms sighted in the resident's individual record evidenced family are informed of any health changes, incidents/accidents, infections, specialist visits, care plan review and weight loss. Family are invited to attend care review meetings.</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>	PA Low	<p>Family members and residents interviewed reported the residents' needs were being appropriately met. During the tour of facility, it was noted that all staff treated residents with respect and dignity. Residents and families were able to confirm this observation. Overall care plans identify the resident's problems/needs, objectives and interventions to assist the resident in achieving their goals.</p> <p>Caregivers reported that they are informed of any changes in health status at handover between shifts and handover records are maintained. When a resident's condition alters, the RN initiates a review by GP in the first instance. There is evidence that family members were notified of any changes to their relative's health including (but not limited to): accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the contact with family member record page held within the resident file.</p> <p>A falls risk assessment is completed on admission and reviewed at least six-monthly or earlier should there be an increased falls risk. All falls are reported on the resident accident/incident form and reported to the RN and clinical nurse leader. Neurological observations are completed for unwitnessed falls or suspected head injuries (sighted). Documentation evidenced RN oversight of resident care, additional</p>

		<p>assessments and/or monitoring records (e.g., repositioning charts and fluid monitoring) were sighted. Adequate dressing supplies were sighted. Wound management policies and procedures are in place. There is access to a district nurse for advice for wound management.</p> <p>Continence products are available and resident files include a continence assessment, and continence products identified for day use, night use, and other management. Wound documentation in both wings were reviewed. The upstairs and downstairs units both had a short-term care plan and wound management folder that included wound assessment and management plans. Not all short-term care plans related to the management of an existing wound had a specific wound assessment and management chart. A sample of wound management records and short-term care plans were reviewed. There was evidence of regular photographs taken of chronic wounds and pressure injuries. The RNs interviewed described the referral process should they require assistance from a wound specialist. Monitoring occurs for weight, vital signs, blood glucose, pain, food and/or fluid intake.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities team (one diversional therapist and two activities assistants) coordinate and implement activities programme across the rest home and hospital. The programme is seven days a week including public holidays. Activities staff attend on-site and organisational in-services relevant to their roles. Volunteers visit throughout the week and on weekends. The diversional therapist makes contact with a resident and their family/whānau within a week of admission. A map of life and an activity care plan is completed within three weeks of admission in consultation with the resident/family/whānau. The map of life is displayed in residents' room which has provided opportunities for all staff and visitors to get to know the resident and their past interests sooner. The activities plan is reviewed six-monthly with the long-term care plan.</p> <p>Attendance sheets and individual progress notes are maintained. Feedback on the programme is received through monthly resident meetings and regular surveys. Residents and relatives interviewed reported that they or their loved one enjoyed the activities offered. The activities programme has set activities with the flexibility to add activities that are meaningful and relevant for the resident group including: exercises as per Otago Falls prevention programme; themed events and celebrations; baking for the homeless; sensory activities including pets coming to visit; young mums club; outings and drives. Each wing of the facility provides a homelike lounge and dining area with seating placed for large and smaller group activities. One-on-one activities occur as well as regular wheelchair walks out around the neighbourhood. Daily contact is made with residents who choose not to be involved in the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery</p>	FA	<p>In files sampled, all initial care plans were evaluated by the RNs within three weeks of admission. The long-term care plans reviewed were evaluated at least six-monthly or earlier if there was a change in</p>

plans are evaluated in a comprehensive and timely manner.		health status in six of eight files sampled (two of the resident's files reviewed had not been at the facility for six months). There is at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing. Where progress is different from expected, the service responds by initiating changes to the care plan.
<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>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referral processes are documented and in place to guide staff to ensure residents are supported and referrals are appropriately facilitated to meet the needs of residents receiving services in this organisation. Residents have the option to use their own GP or one of the three doctors from the contracted medical centre.</p> <p>Residents interviewed report they are given the choice of retaining their own GP but usually change as it is easier to see the GP when he visits. If a resident wishes to change facilities to another health and disability service, the NASC service is contacted and the service provider assists as much as possible with arranging the transfer once approved by the NASC service coordinator concerned. Examples of referrals sighted were to: older person's mental health service; podiatry; physiotherapy; and skin specialist. There is evidence of GP discussion with families regarding referrals for treatment and options of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies in place for waste management, waste disposal for general waste and medical waste management. There are approved sharps containers in use for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals in use are stored securely on the cleaner's trolley. Laundry and sluice rooms are locked when not in use. Material safety data sheets are available in all key areas. The hazard register identifies hazardous substances. Gloves, aprons and goggles are available in key areas for staff. Staff receive education on chemical safety. Interviews with caregivers described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed).</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	FA	<p>Malyon House provides rest home and hospital level care. There are several communal areas provided for both groups and individuals. The interior of the building is maintained with a home-like décor and furnishings. The corridors are wide with handrails in place. Residents were observed to safely mobilise throughout the facility. The service displays a current building warrant of fitness which expires 3 August 2018. Hot water temperatures checks are conducted and recorded monthly by the maintenance person</p>

facilities that are fit for their purpose.		<p>and maintained at 45 degrees Celsius. The service utilises hoists for resident transfer; these are calibrated and have electrical checks annually (last done August 2017).</p> <p>There is sufficient medical equipment to meet resident needs, including: pressure relieving mattresses; shower chairs; wheelchairs; walking frames; hoists; heel protectors; transferring aids; chair scales; blood pressure machine and thermometers. There are several quiet seating nooks throughout the facility providing quiet low stimulus areas and privacy for residents and visitors. There is easy access to the outdoors. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with five caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</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>All but one of the bedrooms are single occupancy (with one bedroom able to accommodate two beds) and have full ensuites with disability showers. There are communal toilets located closely to the communal areas on both floors. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares. Regular audits of the environment are completed as per the quality programme. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The residents' rooms are spacious and meet the assessed resident needs. Residents can easily manoeuvre mobility aids around the bed and personal spaces. The bedrooms are personalised. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place and staff were seen to use hoists. Residents interviewed are happy with their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation,</p>	FA	<p>There are combined lounge and dining rooms in each wing along with a kitchenette. There is also a large communal activities room on the ground floor. The dining areas are spacious and are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed report they can move around the facility.</p>

activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Malyon House has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the laundry staff. Staff attend infection control education and there is appropriate protective clothing such as aprons, gloves and masks available. There are dedicated laundry and cleaning staff. Manufacturer's data safety sheets are available. On a tour of the facility, the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. Cleaning audits are conducted. Internal audits and resident satisfaction surveys identify any areas for improvement.</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>. The service has a generator for emergency power. There is a civil defence kit available and first aid supplies.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Heating and cooling is centrally managed with heat/cooling pumps throughout the facility. Staff are easily able to adjust the temperatures to suit resident's needs. Residents and family interviewed state the environment is warm and 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</p>	FA	<p>Malyon House has an established infection control (IC) programme that is appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the designated infection control nurse and responsibilities for the role is described in the job description. Infection control data is discussed at the qualified staff meetings and general staff meetings and is reported monthly to the Cavell group for benchmarking with other facilities. Infection control education has been provided for staff. The infection control programme is well established at Malyon House and has been reviewed in the past 12 months. There have been no outbreaks since the previous audit</p>

appropriate to the size and scope of the service.		
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Malyon House. The infection control coordinator (clinical manager) has completed education in infection control in past 12 months. The role of infection control coordinator is being formally handed over to the newly appointed clinical manager (current clinical nurse leader) following the audit. 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.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a range of policies, standards and guidelines and includes roles, responsibilities, procedures, and training and education of staff. The policies and procedures which reflect best practice are accessed by the service through the local DHB.</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>The Infection control coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around (but not limited to) hand hygiene and standard precautions. Infection control training is part of the mandatory one-day training programme which is regularly held throughout the year to ensure all staff attend at least annually.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	<p>The infection control programme describes and outlines the purpose and methodology for the surveillance of infections. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. Short-term care plans</p>

carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		<p>are used. This data is monitored and evaluated monthly and annually. The infection control programme is linked with the quality management programme. Outcomes and actions are discussed at the facility's management meeting, RN and staff meetings. There have been no outbreaks since the last audit.</p> <p>The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. There is close liaison with the general practitioners that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The 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 confirm their understanding of restraints and enablers. At the time of the audit, the service had no residents using restraints and one resident with bedrails as an enabler as requested by the resident. Staff training has been provided around restraint minimisation and management of challenging behaviours.</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>	CI	<p>Individual approved restraint is reviewed at least three-monthly through the restraint meeting and as part of restraint evaluations. Restraint usage throughout the organisation is also monitored regularly and reported monthly to the Cavell Group. Throughout the 2016 and 2017, the service has actively worked on minimising the use of restraint with the aim to become restraint free. On the day of audit, there were no residents requiring the use of restraint and one resident who have requested the use of a bedrail as an enabler.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers'</p>	PA Low	<p>Not all short-term care plans related to the management of an existing wound had documented evidence of a specific wound assessment and management chart as per the organisations wound management policy. The service explained that for non-complex wounds, a short-term care plan is initially created that documents the wound and specific management of the wound. Where the wound continues longer than four weeks or deteriorates during that time, it is then transferred to the wound assessment and management plan. However, two of four wound short-term care plans in place for longer than four weeks, did not have a specific wound assessment or management plan. Two of four wound short-term care plans had been transferred to wound assessment and management charts three and six months after the initial STCP had been created.</p>	<p>The following shortfalls were identified in the files reviewed</p> <p>Six of eight wound short-term care plans reviewed did not have a formal documented initial wound assessment and management charts completed; (iii) Two of four short-term care plans in place longer than four weeks did not have a documented wound assessment or management plan and; (iv) One wound assessment and management record had been completed three months and one at</p>	<p>Ensure there is documented evidence of initial wound care assessments and ongoing management for all wounds.</p> <p>60 days</p>



assessed needs, and desired outcomes.			six months after the initial short-term care plan had been commenced.	
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p>	CI	<p>The service is proactive in minimising restraint. The Restraint Committee meets monthly and all restraint and at-risk residents are monitored closely to determine alternatives to restraint. Individual approved restraint is reviewed at least three-monthly as part of the Restraint Committee meeting. Restraint usage throughout the organisation is also monitored regularly and reported monthly to the Cavell Group. Throughout the 2016 and 2017, the service has actively worked on minimising the use of restraint with the aim to become restraint free. On the day of audit, there were no residents requiring the use of restraint and one resident who had requested</p>	<p>In April 2016, the service had nine residents with bedrails as restraint and recognised that this number was too high for a facility of fifty-six residents. Whilst the facility manager (RN) had previously been the restraint coordinator, the service did not have a formal approval group/restraint committee in place. A restraint approval group and committee was formed, consisting of the clinical manager, physiotherapist, the GP and a senior caregiver. Regular meetings were held to discuss ways in which the service could reduce the incidence of restraint in the facility and to evaluate how certain interventions were working. New equipment for use as an alternative to restraint was identified and purchased (e.g., landing strips/crash mats, perimeter</p>

<p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>		<p>the use of a bedrail as an enabler.</p>	<p>mattress, bed levers and hi-low beds).</p> <p>Hazard assessments forms were also completed for this new equipment. The restraint policy was reviewed and included use of enablers. Restraint management/minimisation is also discussed at each staff meeting and at monthly management meetings. The service focused on educating staff regarding the risks of restraint, alternatives to restraint and the approval process during the mandatory education day(s) provided to ensure that all staff attend at least annually. The service has achieved a restraint-free environment since November 2017.</p>
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End of the report.