

Metlifecare Limited - The Orchards

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Metlifecare Limited
Premises audited:	The Orchards
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 July 2018 End date: 11 July 2018
Proposed changes to current services (if any):	The service wishes to add non-acute medical services to their service delivery.
Total beds occupied across all premises included in the audit on the first day of the audit:	30

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Metlifecare Limited - The Orchards (The Orchards) provides rest home and hospital level care for up to 32 residents. The service is operated by Metlifecare Limited. There is a village manager who has overall responsibility and accountability for services offered and a registered nurse is the nurse manager of the care unit. They are supported by a team of registered nurses with one nurse being the nominated senior nurse on the floor. The food services manager is the third member of the management team. Residents and families spoke positively about the care provided.

The service would like to have non-acute medical added to the services they offer. This will not mean an increase in bed numbers. The audit identified that the current services and the environment are suitable for this service to occur. The service can demonstrate their ability and preparedness to include this service.

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

This audit has resulted in no areas requiring improvement being identified.

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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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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 facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical and biomedical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support a restraint free environment. No enablers or restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process is available should restraint be required. Policy states that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	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 facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
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 consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. There are internal and external areas throughout the facility, including two lounges and a café which residents and visitors can use, other than meeting in the resident's bedroom when visiting.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaints information is available at the entrance to the facility. Resident satisfaction survey results for July 2018 showed that response to family concerns gained a 97% rating which is an increase from 82% in 2017.</p> <p>The complaints register reviewed showed that six complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans identified any required follow up and improvements have been made where possible. One example relates to a complaint about food services. The follow-up has resulted in a hardcopy of the current menu being placed in the information holder in each resident's bedroom as well as the weekly menu from which residents choose what they wish to eat daily.</p> <p>The nurse manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. All complaints are reported to the quality and risk manager and discussed at the clinical senior management meeting as required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in the main foyer area of the facility together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by attending community activities, participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The senior registered nurse interviewed reported that there were currently no resident who affiliate with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is no specific Maori health plan; however, a Maori Health resource manual has been developed and currently is in draft. The Maori resource manual supports all values and beliefs acknowledged within the Te Whare Tapa Wha model with input from cultural advisers within the local community as required helping to support and develop a Maori health care plan for the resident. With the resident's consent a referral form is completed and sent to the local rohe for ongoing support. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>being met.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included observation of conversations between residents, families and staff, and the knocking on bedroom doors before entering.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required to support the three residents who do not understand English due to the use of and regular visits of family members, communication cards and the staff knowing the residents well. There are six residents acknowledged with a significant sensory impairment and appropriate equipment and resources were sighted and highlighted in residents' long term care plans reviewed.</p> <p>Each month an updated activities calendar, a copy of the monthly resident meeting meetings and</p>

		current menu is provided to each resident's room.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly management reports to the clinical governance committee and quarterly reports to the board of directors showed adequate information to monitor performance is reported including financial performance, quality improvements, clinical quality data, staffing, complaints, incidents and accidents, occupancy, emerging risks and issues.</p> <p>The overall service is managed by the village manager who has been in the role for six weeks. She has previous aged care management experience. The care unit services are overseen by the nurse manager who holds a current registered nurse practising certificate and has been in the role for over two years. The food services manager oversees all catering services and has been in the role for two years. All three managers hold relevant qualifications. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The management team confirmed their knowledge of the sector, regulatory and reporting requirements and they maintain currency through ongoing education, such as attending Metlifecare two monthly 'webinars', nutrition education via Massey university, Waitemata DHB education days and attendance at age care forums and conferences.</p> <p>The service holds an Age Residential Related Care contract with the Waitemata District Health Board which includes respite care. All 30 residents were receiving services under the contract; being six rest home level care and 24 hospital level care residents at the time of audit.</p> <p>The interRAI level of care report matched the number of residents and levels of care offered.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the nurse manager is absent, the senior registered nurse with assistance from the clinical quality and risk manager from Metlifecare, carries out all the required duties under delegated authority.</p> <p>During absences of key clinical staff, the clinical management is overseen by a registered nurse from the floor who is experienced in the sector and able to take responsibility for any clinical issues with assistance and oversight of the nurse manager. Staff reported the current arrangements work well.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls, wounds and pressure injuries.</p> <p>Quality data collected is analysed to show trends. Benchmarking is undertaken against all Metlifecare clinical units and infection control benchmarking is undertaken against other like facilities by an off-site company every three months. Issues that arise are managed via the corrective action process and outcomes are documented.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting, the clinical governance group at Metlifecare senior management level, specific committee meetings such as health and safety and infection control, and staff meetings. Staff reported their involvement in quality and risk management activities through active involvement in specific committees, audit activities and projects and the implementation of corrective actions.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Examples were sighted related to corrective actions related to falls which included staff education and the placement of additional handrails in the corridors, and the investigation related to the length of time for staff to respond to call bells which included discussion at staff meetings, approval from head office to have an accelerated call bell response implemented and the introduction of daily allocation of residents to a specific staff team. Staff confirmed their awareness of the corrective actions and feel they have had positive outcomes. This is supported by the overall resident/family satisfaction survey results which gained a 96% rating.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey, June 2018, showed that all areas of service gained a higher rating in all areas from the 2017 year. Issues raised in the 2017 satisfaction survey such as food services have corrective actions shown with staff responsibilities and outcomes identified. Corrective actions included ensuring all residents' food needs are catered for and this includes the introduction of an off-site specialist pureed food company supplying pureed food and the use of food moulds to make the meal look more attractive. Residents and families interviewed confirmed there has been an improvement in food services over the past year. The facility has undertaken a project around this process and outcomes are yet to be fully evaluated.</p> <p>The Orchards has four active quality improvements which they are working on. These are the introduction of an electronic programme to access off-site clinical information such as blood tests, hourly electronic fridge testing of temperatures to prevent food spoilage, residents on fortified foods and those having puree food is being linked to monitoring of residents weight to ensure they increase or remain stable, and the ongoing management of falls with a 30% of falls as a set goal.</p>
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<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Information is used to improve service delivery where appropriate. Adverse event data is collated, analysed and reported to the senior registered nurse, the nurse manager, the village manager and electronically recorded for the quality and risk manager to review. All incidents and accidents are reported at management and staff meetings.</p> <p>The nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there have been two section 31 notifications of significant events made to the Ministry of Health and one norovirus outbreak reported to public health in August 2017. The section 31 reports were: 07 December 2017 related to a resident with memory loss being reported as a missing person. A police report was completed but not acted upon as the resident returned to the facility themselves one and a half hours after they were noted to be missing. Family were kept informed. The second report related to the electronic medication system being down and that off-line data was not up to date. This resulted in a corrective action being put in place, and following staff education, all medication electronic data is now backed up following each medication round. This was confirmed on the day of audit.</p> <p>There have been no police investigations, coroner's inquests or issues-based audits.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a ninety-day period and then annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Metlifecare have a dedicated staff member who is the internal assessor for the programme for the Northern cluster of facilities. Training is undertaken both on-site and off-site. The Orchards are members of the Waitemata DHB Community Adult Health Service Residential Aged Care Integrated Programme (RACIP) which allows staff to access relevant DHB training. There is also a memorandum of understanding with Waitemata DHB which allows the facility to gain specialist clinical coaching for staff which is presented on-site by the gerontology nurse specialist and/or the wound care nurse specialist. The ongoing education covers all aspects of aged care service delivery and includes non-acute medical conditions.</p> <p>There are two trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. The process used includes resident acuity and would apply to non-acute medical care as well as rest home and hospital. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24//7) RN coverage in the care unit.</p> <p>The nurse manager works 8am to 4.30 pm Monday to Friday and the senior registered nurse works 8.30am to 5pm Tuesday to Saturday. Monday and Sunday have an additional registered nurse on the floor to cover the senior registered nurse duties. There is another registered nurse from 6.45am to 3.15pm and four caregivers seven days a week. Afternoon shift has one registered nurse from 3pm to 11.15pm, two caregivers from 3pm to 11pm and two caregivers from 3pm to 10pm seven days a week. Night duty has one registered nurse and two caregivers from 11pm to 7am seven days a week. An</p>

		<p>additional caregiver is rostered from 6.45am to 2.15pm when resident number increase to 32 or if there is a heavy workload.</p> <p>Domestic aid cover is 8am to 4.30pm five days a week, 8.30am to 4pm Monday and Tuesday, 8am to 2.30 Wednesday, Thursday and Friday and 8am to 4.30 pm Saturday and Sunday. The activities coordinator works 10am to 4.30pm Monday to Friday. The kitchen is fully staffed seven days a week and the staff are employed by the village but undertake all cooking and serving duties for the care unit. There is night porter who also acts a security person seven nights a week from 11pm to 7am.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and/or GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit,</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example</p>

<p>discharge, or transfer from services.</p>		<p>reviewed of a patient recently transferred to the local acute care facility showed communication between the facility, hospital, ambulance staff and family and documented outcome of the transfer. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge were within the recommended range and are monitored by an external company. The facility offers flu vaccines; however, all vaccines are provided by an external source and no vaccines are stored on site.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. The facility does not use standing orders.</p> <p>There were three residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are</p>	<p>FA</p>	<p>The food service is overseen by a food service manager and provided on site by two cooks and a kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p>

<p>met where this service is a component of service delivery.</p>		<p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration has been issued by the Auckland City council and expires 11 June 2019. The residents also have access to an external café on site of the facility which also has an approved safety plan and expires on the same date as the main kitchen. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager and cooks have undertaken a safe food handling qualification, with kitchen assistants currently completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. The total numbers of beds would not change with the addition of non-acute medical residents, and the kitchen manager interviewed stated that they can manage all menus and different food diets for all residents.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional needs, and incontinence screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. Two residents are awaiting transfer of their files to the facility, evidence was sighted from the facility requesting that the transfer of this information occur. Long term care plans were sighted. All other residents have current interRAI assessments completed by one of two trained interRAI assessors on site. The nurse manager interviewed stated that currently there is no formal plan to train further registered staff at the facility. Residents and families confirmed their involvement in the assessment process.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by an activities co-ordinator who supports residents Monday to Friday 10 am to 4.30 pm. The programme is currently overseen and supported by an occupational therapist who visits the facility as required and supports the activities co-ordinator who is training to become a diversional therapist.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly and as part of the formal six monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, and satisfaction surveys. Residents interviewed confirmed they find the programme interactive and interesting.</p>
<p>Standard 1.3.8: Evaluation</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to mental health services for older people, dietician and a speech language therapist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Safe waste management is included in staff orientation. Staff who handle chemicals are required to undertake safe chemical handling education. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 22 March 2019) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment (22 May 2018) and calibration of bio medical equipment (December 2017) is current as confirmed in documentation</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. Oxygen is well secured. Full environmental safety audits are carried out twice a year and this was last undertaken in February 2018. Maintenance is scheduled electronically and is easy to track and view completion dates. Regular checks are undertaken by an off-site provider for sluice room, kitchen and laundry equipment.</p> <p>The service has adequate equipment to cater for non-acute medical residents, this includes sit on weigh scales, two full sling hoists and one standing hoist and a bariatric wheel chair and toilet chair.</p> <p>There is an external balcony area off the lounge area which has an emergency call bell, suitable seating, room for wheelchairs and sun shade. Residents can also access the gardens via the lower level. The garden paths are well maintained. The outdoor areas are appropriate to the resident groups and setting. Residents confirmed they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes eight bedrooms that have toilet ensembles and all the remaining bedrooms have full ensuite facilities. Two communal bathroom areas have wide door access and can easily accommodate any lifting equipment required. Regular water temperature testing identifies that a safe range is maintained. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Bathrooms are suitable for non-acute medical residents.</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>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>Bedrooms are large enough to store wheelchairs and scooters. The doorways are wide enough to move equipment and beds as required. All the beds are electric and regular maintenance is undertaken as sighted in documentation. The room size is adequate for non-acute medical residents. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation,</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. There are two dining areas, an entertainment room with restricted times of use owing to no natural light and a lounge area. All areas</p>

<p>And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>provide adequate space and enable easy access for residents and staff. Furniture is appropriate to the setting and residents' needs. As the bed numbers are not increasing the current communal areas can accommodate non-acute medical residents as required.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry by domestic staff. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The 2018 resident satisfaction survey gained a 96% rating.</p> <p>The laundry is well equipped, and staff confirm they can manage the volume of laundry for all residents.</p> <p>There is a small designated cleaning team who have received appropriate training which includes safe chemical handling as confirmed in staff interviews and training records. Chemicals are securely stored and were in appropriately labelled containers. Infection control management processes are on display in the laundry in the form of a flip chart for easy staff access as well as clearly set out in policy and procedures. Staff confirmed their understanding of outbreak management and verbalised the actions taken during the norovirus outbreak.</p> <p>Cleaning and laundry processes are monitored through regular checks by the chemical provider and the internal audit programme. The recent resident satisfaction survey results identified that overall cleanliness gained a 97% rating which increased from 90% in 2017.</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>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 04 January 2018 when all buildings on the complex were completed. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in April 2018 with one corrective action being identified and implemented by the service. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas cooking facilities were sighted and meet the requirements for the 32 residents. Ten litre water bottles are stored in two areas of the care unit and this includes an aqua valve and</p>

		<p>cradle for ease of use. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis. These have identified that in some cases it is taking over 10 minute for staff to respond. This has been fully investigated by the nurse manager and documented corrective actions are being implemented. Most instances are staff not turning off the call bell when they first respond to the resident's needs. Metlifecare head office has approved the installation of a graduated call system so that if the call bell is not responded to within eight minutes it will be escalated to the senior registered nurse on duty graduating up to the nurse manager. On the days of audit residents and families reported staff respond promptly to call bells. Maintenance staff check call bells monthly and an off-site provider undertakes a full check of call bells and staff pagers annually. This last occurred on 03 July 2018 and two staff pagers which were not working correctly were replaced.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the night porter undertakes regular checks of the external doors and windows during the night. All windows have restrictor stays to ensure the windows cannot open fully.</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 residents' rooms and communal areas are heated and ventilated appropriately. The air conditioning units can be controlled to individualise each resident's bedroom to a temperature they are comfortable with. With the exception of the entertainment room, which has restricted use hours, rooms have natural light and opening external windows. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from a clinical nurse specialist, GP and pharmacy. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the senior registered nurse and nurse manager and tabled at the quality/risk committee meeting. This committee includes the nurse manager/ senior registered nurse, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long</p>

		they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
<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>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for six months. She has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</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 prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2018 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when the facility had a gastro enteritis outbreak in August 2017.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about</p>

		handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the monthly surveillance programme are shared with staff via staff meetings, on the notice board in the staff room and at staff handovers.</p> <p>The facility has had a total of 10 infections in the hospital and no infections in the rest home from January 2018 to June 2018. The residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. As of May 2018, 23 staff and 30 residents consented to and have had the flu vaccine this year. Infection data is benchmarked externally within the group and QPS three monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a gastrointestinal infection outbreak (August 2017) where 15 residents and 10 staff members were affected was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. Policy identifies that Metlifecare facilities aim to be restraint free. The Orchards had no enablers or restraints in use at the time of audit. The restraint coordinator provides support and oversight for enabler and restraint management should it be required. The terms of reference for the restraint committee identify the role and responsibility of the members. The committee meets three monthly and meeting minutes are documented. As there is no restraint the meetings are used to plan staff education and ensure that all restraint policies and procedures are up to date. Staff education was last presented in November 2017.</p> <p>The restraint free environment was confirmed during staff interview, in meeting minutes and in the</p>

		<p>restraint register. The last enabler use ceased in September 2017. Policy states that enablers are the least restrictive method and only used upon voluntarily resident request.</p> <p>The restraint coordinator confirmed that restraint would only be used as a last resort when all alternatives have been explored.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.