

ABI Rehabilitation New Zealand Limited

Introduction

This report records the results of a Surveillance Audit of a provider of residential disability 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:	ABI Rehabilitation New Zealand Limited
Premises audited:	Multiple premises
Services audited:	Hospital services - Medical services; Residential disability services - Physical
Dates of audit:	Start date: 15 August 2018 End date: 17 August 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	65

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

ABI Rehabilitation New Zealand (Auckland) provides intensive rehabilitation hospital (medical) level care for up to 33 clients and residential disability services to people who have had a traumatic brain injury or stroke for up to 43 clients in six houses in the west of Auckland. The service is operated by ABI Rehabilitation New Zealand Ltd and managed by a managing director. Since the certification audit, one residential house has been closed.

This surveillance audit was conducted against the Health and Disability Services Standards. The audit process included review of policies and procedures, review of clients' and staff files, observations and interviews with clients, family members, management and staff, including allied health providers and a doctor.

This audit has identified areas for improvement relating to food and nutrition and adverse event records. Nine areas identified as requiring improvement at the previous audit have now been fully addressed.

On the day of audit there were 65 beds occupied; 25 intensive rehabilitation clients were at the Metcalfe Road site and 40 clients in the community houses. One day rehabilitation client was also present at Metcalfe Road. A total of three houses in the community were visited during the audit as well as one house at the main Metcalfe Road site.

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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All requirements related to clients' rights related to independence, personal privacy, dignity and respect are complied with. Clients and family members spoken with during the audit expressed satisfaction with the services being provided.

Clients and their families are provided with the information that they need to make informed choices and were appreciative of this. Open communication between staff, clients, and families is promoted. There is access to interpreting services which are used when required.

A complaints register is maintained and demonstrated that complaints are 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.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk management plans include the key objectives, values and mission statement of the organisation. Regular and effective monitoring of the services is provided by the executive management team to the Managing Director.

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 clients and families. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures, which are updated regularly, support service delivery.

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 clients.

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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ABI (Acquired Brain Injury) Rehabilitation provides specialist residential and community-based rehabilitation. A multidisciplinary team that comprises medical officers, physiotherapist, occupational therapists, speech language therapist, registered nurses, a dietician, rehabilitation programme coordinators, provide rehabilitation planning, assessment, interventions and evaluation of care.

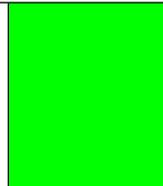
Activities are therapy based in the intensive service and the residential service provides activities that are appropriate to its client group.

Medication is managed via Medi-Map which is well embedded in the service and implemented in accordance with the organisation's policies and procedures and requirements. Staff involved in medication management are assessed as competent to do so.

The food service is based on the requirements of individuals and is monitored by a dietitian. A rotating four weekly menu provides the basis for meals with daily input from the multidisciplinary team.

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.

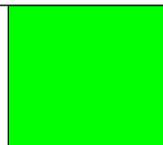


Standards applicable to this service fully attained.

A current building warrant of fitness was displayed at relevant sites.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. Two clients were using enablers and twenty three clients were using restraints at the time of audit. A comprehensive assessment, approval and monitoring process with regular fortnightly or monthly reviews is occurring. Use of enablers is voluntary for the safety of clients in response to individual requests. Staff have regular training in challenging behaviours and restraint minimisation techniques.

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 control programme is suitable for the size and type of the service. Surveillance is undertaken appropriately and reported via the clinical governance 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	0	18	0	2	0	0	0
Criteria	0	44	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>A process is in place that ensures the informed consent process is explained to clients and their families on admission to the service. Signed forms were sighted on the twenty-six files sighted across both the intensive and residential services. This addresses the previous corrective action. The consent forms cover all aspects of the service that the client might be involved in, including the taking of photographs and the discussion with clients and families around ‘not for resuscitation’, which involves a discussion with the medical director. Informed consent was sighted on appropriate forms where restraint and/or enablers are used. Informed consent forms are re-signed if the client is still in the service in three years.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The compliments/complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). Information on the complaint process is provided to residents and families on admission and is placed around the facilities. Those interviewed knew how to make a complaint or give compliments.</p> <p>The complaints register reviewed showed that 29 complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and processes completed within the timeframes. Four complaints were referred to the Health and Disability Commissioner (HDC). Three were resolved and are</p>

		<p>now closed and one is currently being working on with other agency involvement with all required documentation having been forwarded to the HDC. Action plans showed any required follow up and improvements have been made where possible. The quality, risk and compliance 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.</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>The clients and families interviewed reported staff are always respectful and considerate about their right to privacy. Staff interviewed were aware of the policy and able to discuss the process to report abuse and neglect if they were to suspect it.</p> <p>All clients have their own bedrooms and care is taken to ensure privacy when using shared bathrooms. Client's preferred names are used by staff and this is documented, as was evident with one of the clients reviewed in detail using tracer methodology. An organisation wide privacy audit is conducted three monthly and results are reported to the clinical governance group. The laundry staff no longer receive information about clients' infections, this is addressed with colour coded linen bags and this addresses the previous area requiring improvement.</p> <p>Client's needs, values, and beliefs are assessed at first entry to the service and this information is documented on the initial assessment form.</p> <p>The clients and family members interviewed confirmed that their wishes are respected and had high praise for the quality of care provided and the marked improvement in the clients' progress and wellbeing since being in the service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Clients and family members interviewed felt well informed about their care, and confirmed they are involved in helping to work towards their/their relative's goals. They reported that staff take the time to listen and seek their opinions and work in partnership with them. One family had been given exercises and games they could play with the client to promote their rehabilitation programme and understood the value of this.</p> <p>Where applicable, the client and/or family are informed following any adverse event and this is documented both on the incident form and in the clinical record. Two staff members discussed this.</p> <p>Interpretation services are accessed in one residential home and staff are aware of the process of how to do this. In several cases, family members or staff members can be used to support communication when this is necessary. Examples of this were discussed with staff.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic plan (2018-2021) and associated business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the operational plans have key measures outlined. A sample of quarterly reports to the managing director showed adequate information to monitor performance is reported, including progress against the business planning goals.</p> <p>The service is managed by a Managing Director who is the business owner and who also set up this ABI Rehabilitation service. He is supported by two general managers and a medical team chair, all of whom have current job descriptions and individual employment contracts. The Managing Director has significant knowledge of the sector, regulatory and reporting requirements and maintains currency through involvement in current research programmes and regular work with the international Commission on the Accreditation of Rehabilitation Facilities (CARF) programme the organisation is involved in.</p> <p>The service holds contracts with a number of DHB's, ACC and the MoH for intensive rehabilitation services, hospital medical, traumatic brain injury specialist residential rehabilitation, long term chronic health and residential support services. Sixty-six (66) residents were receiving services under the contracts (53 under the ACC contracts, 8 under the DHB contracts, four under MoH contracts and one private client) at the time of audit. This number includes one day rehabilitation client.</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, internal audit activities, a regular client and family satisfaction survey, monitoring of outcomes, clinical incidents and health and safety. The majority of these are managed on an electronic risk management programme.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators. The related information is then reported and discussed at executive management meetings as well as individual management and the relevant discipline team meetings. Staff reported their involvement in quality and risk management activities through audit activities as well as their individual team meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. These are all analysed and reported in the annual report. All clients discharged from the intensive service complete satisfaction surveys with families and any issues are followed up. The residential services have an annual survey completed. Changes in how the service communicates with families returning clients after weekend leave is one response noted.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements. Policies are based on best practice and were current. The electronic document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The quality, risk and compliance manager described the processes for the identification, monitoring, review and</p>

		<p>reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>Previous areas identified at the certification audit as needing improvement have now all been addressed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>Staff document adverse and near miss events on an 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. Organisational procedures require the information to then be loaded onto the database linked to the quality system. This is not always being completed.</p> <p>The quality, risk and compliance manager described essential notification reporting requirements. They advised there have been no notifications of significant events made to the Ministry of Health or the DHB's since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	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 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 showed documentation of completed orientation and a performance review after a three-month period. Performance reviews are again completed at nine months and then annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Rehabilitation assistants, nursing and therapy staff have either completed or commenced a New Zealand Qualification Authority education programme as relevant. A staff member is the internal assessor for the programme. Education records reviewed demonstrated completion of the required training. Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs, supervision requirements and review competencies. They also report the company encourage and support all training opportunities both external and internally. Appraisals were current for all staff.</p>
Standard 1.2.8: Service	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>service delivery, 24 hours a day, seven days a week (24/7). The facility at Metcalfe Road is continually adjusting staffing levels to meet the changing needs of residents in the intensive service which is based on the Northwick Park Rehabilitation Complexity Scale. Two registered nurses (RN's) are on duty overnight with a minimum of two RN's on all other shifts. Allied health staff and rehabilitation assistants are rostered at all facilities.</p> <p>The staffing at the residential houses is also adjusted to respond if client needs change. RN coverage is in place for all shifts. An afterhours on call roster is in place, including medical cover, with staff reporting that good access to advice is available when needed. Rehabilitation staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a six-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All shifts have staff with current first aid training.</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>There are documented policies and procedures for all aspects of medicine management. ABI uses a community pharmacy to supply medications in robotic packs, all of which are prescribed for individual clients; no extra stock is carried. Medication was securely held in all the facilities visited, in a locked cupboard within a locked office. Medication fridges are held in all facilities but very few medications are held in these at most sites.</p> <p>The service uses Medi-Map and this is well embedded in the service. It is also used by the community pharmacy that provides the pharmacy service and this enables a streamlined service with good communication between staff and the pharmacy. Medication is delivered by the pharmacy and there is a robust checking process against the prescriptions before medication is taken to each house. The pharmacy is now involved in auditing of controlled drugs and the previous corrective action is now addressed.</p> <p>A cold chain policy has been written and temperatures are being monitored, this has addressed the previous corrective action.</p> <p>All staff undertaking medicine administration are assessed annually as competent to perform the role, and all were current.</p> <p>Self-administration occurs as part of the rehabilitation process. Clients deemed suitable to self-administer adhere to a three-phase process of learning and are required to undertake a test to prove their competence. Appropriate storage of medication is undertaken during this process.</p> <p>Medication errors are recorded using the incident reporting form and are reported via the clinical governance group, and where appropriate discussed at staff meetings.</p> <p>Allergies and sensitivities are clearly documented on Medi-Map and are noted on the handover board. All persons using Medi-Map have their own login that is attributable to the actions they undertake on the programme. No standing orders are used.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>An in-house, employed, trained cook provides the food service in the intensive service. A food safety programme has been submitted to the local council and the recommendations from this are being worked through by the service. A dietician is on site weekly and visits the residential homes two monthly and was observed discussing diets with clients. A core menu is planned on a four weekly rotation and changed seasonally. Nutritional needs are closely monitored with some clients keeping a food diary and having a regularly weigh. Supplementary milkshakes are available as desired for underweight clients. Special diets are readily available, for example, diabetic, dairy and gluten free, soft, and the cook is aware of the requirements and his responsibilities for these. These aspects of the previous corrective action have been addressed.</p> <p>In the residential service fridge and freezer temperatures are monitored, but there is a lack of guidance for staff to follow should these temperatures fluctuate outside the accepted parameters and there is an improvement required for this. Meat supplied to the residential service now has packaged dates and this addresses the previous corrective action.</p> <p>In the intensive service menus are reviewed daily for all clients and these are signed off by the SLT, RN and RPC before giving them to the cook in the evening for the next day. The cook discussed being aware of when client's requirements change from soft to general diets, and he shares in the pleasure of clients' progress.</p> <p>Where the residential service uses pureed food, this is purchased externally and delivered frozen. The dietician monitors this service. In some homes clients help staff to cook meals as part of their rehabilitation programme activities.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in</p>	<p>FA</p>	<p>Service delivery is guided by the philosophy of ABI. The care and rehabilitation services provided are specifically designed for the client's assessed needs and desired outcomes. Service interventions are an integral part of the rehabilitation programme. Plans are focused on the clients' goals. Plans are made with the client if they are cognitively able, or with their family and one family were able to discuss this.</p> <p>In the intensive service the client's day is programmed around their interventions and these include rest periods.</p>

<p>order to meet their assessed needs and desired outcomes.</p>		<p>Each goal is accompanied by interventions that the MDT therapists work towards each day. In both services progress is documented at each contact and as the client achieves steps towards their goals. Changes in interventions are documented as protocols, and all staff sign the protocols to ensure that they are giving the care and treatment that is required. In the residential service interventions are not the main focus of the client's day but all interventions are documented and contribute towards the persons goals.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Activities in the intensive service are planned as part of the client's individual rehabilitation programme and are predominantly based around occupational therapy and physiotherapy. Two families spoken with were engaged in undertaking meaningful activities with their family member while they were visiting. All activities are meaningful and contribute towards the clients' programmes.</p> <p>In the residential service where the rehabilitation programme is not so intensive, there is an opportunity for clients to undertake more everyday activities alongside their rehabilitation programmes. One home tries to take clients out for a trip on a Friday; they may visit the Zoo, Butterfly Creek, the museum, for example. Photographs of trips were displayed in the home and people reported enjoying these outings. As able, some clients go home with family for days or weekends. Where clients are unable to go into the community (due to inappropriate behaviour, for example), there are a variety of in-house activities that are available (eg, board games, baking, singing). In one home it was observed that staff were engaged with clients doing activities as was a family member in the other home.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Each goal has a number of interventions, most are related to a therapy, and they are evaluated by each of the therapists. Interventions will be at planned times during the week and after each contact the therapist will document the progress of the interventions. In the intensive service there is evaluation and documentation by each of the therapists after every intervention. Handover meetings between MDT members discuss progress during the previous shift. In the residential service a formal evaluation, clinical review, is undertaken by the MDT at a Wednesday meeting where all clients in a specific house are reviewed. All longer term clients in the service have an annual clinical review.</p> <p>Where progress is noted, interventions are changed to reflect this, for example a person may only be standing then progress to walking with aid and eventually to walk unaided. Each time this intervention changes it is documented in a protocol and all staff sign to say they understand this change. If there is any training required for an intervention, therapists will instruct staff if they are unsure. Likewise, where there is no progress or an intervention is not achievable, it is changed to a different level or replaced with a different intervention and this is monitored in the same way as above.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is publicly displayed at Metcalfe Road (expiry 18/12/18), and two at Swanson Road (expiry dates: 21/10/18, 13/08/19). 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 and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. A maintenance register is now in place for all houses with checking and prioritising of jobs being completed. A previous corrective action around the required checking of all equipment, asset registers and maintenance processes have now been addressed and this standard is now fully achieved.</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>	<p>FA</p>	<p>The infection control programme, which was sighted, has been updated for 2017/18. The infection control team meet three monthly and have reviewed their terms of reference. The committee is now keeping minutes of their meetings and these were sighted. This was a corrective action from the previous audit and has now been addressed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The service has determined the type of surveillance appropriate to the whole service and has recently introduced a process for capturing these infections directly from the client management system. In the intensive service methicillin-resistant Staphylococcus aureus (MRSA) is swabbed for routinely on all clients and treated where appropriate. Urinary tract and respiratory infections are the most common infections recorded across both services. Results are graphed, collectively for both services, and presented to the clinical governance group where trends are monitored.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint</p>	<p>FA</p>	<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. The restraint coordinators provide support and oversight for enabler and restraint management at the Metcalfe Road facility and the residential houses. Both demonstrated a sound understanding of the organisation's policies, procedures and practice and their roles and responsibilities.</p>

<p>is actively minimised.</p>		<p>On the day of audit, a total of 23 residents were using restraints and two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was confirmed by the regular restraint review documentation of those clients who have approved restraints and from interviews with staff. Given the nature of the service, it is sometimes necessary to implement some form of restraint, but this is usually on a very temporary basis until the client can give approval for supports to remain safe. The more common form of supporting many clients with high needs practised is having one on one supervision.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Documentation for adverse event is not being fully completed as per the required procedures. Individual client files checked were all being completed as required with relevant corrective actions being implemented, but the investigation details are not then transferred into the main quality electronic recording system. The system is used by the quality manager to analyse incidents by type and frequency to inform the quality programme and translate into any corrective activity planning that may be appropriate at an organisational level. Forty-seven (47) events currently remain incomplete on the database in the period 1 January to 1 July 2018. An email alert system is in place, but this has not resulted in the required responses from managers.</p>	<p>While all adverse events are documented on the required forms with any actions detailed, not all documentation is being transferred onto the organisational database with the outcomes noted, which then allows for appropriate analysis to be completed and included in the quality system.</p>	<p>Ensure all staff load the required adverse documentation onto the quality database in line with organisational procedures.</p> <p>180 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of</p>	PA Low	<p>As part of the process to address the previous corrective action, new thermometers for fridges and freezers have been purchased for some</p>	<p>One home recorded refrigerator</p>	<p>Ensure guidance is available for staff to</p>

<p>food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>		<p>homes. The RN acknowledged that not all thermometers have been replaced. Temperatures of fridges and freezers were recorded daily in all the homes visited. However, there was no guidance for staff to follow about the required temperatures, or what to do if the temperatures are outside of the accepted parameters, which was the case in one of the homes visited. Staff were asked what they would do in this circumstance but were not sure. This is part of the previous corrective action that has not been addressed and remains open. The risk is reduced to low because the other aspects of this corrective action have been addressed, as described above.</p> <p>Freezers in homes visited have temperature monitoring as above, but ice had built up in both of these and was impinging on the seals. No check list of defrosting was available although staff stated that they knew it should be done fortnightly.</p>	<p>temperatures that have fluctuated daily for six days above the normal parameters. There was no evidence that any action has been taken to investigate this. Freezers in two homes are iced up and need defrosting.</p>	<p>follow when fridge temperatures are outside of normal parameters and required actions are documented. Ensure that freezers are defrosted according to the house rules and this is signed for when done.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.