

Age Care Central Limited - Maryann Rest Home and Hospital

Introduction

This report records the results of a Surveillance 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:	Age Care Central Limited
Premises audited:	Maryann Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 1 November 2018 End date: 2 November 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:	44

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

Maryann Residential Home and Hospital provides dementia, rest home and hospital level care for up to 48 residents. The service is operated by Age Care Central Limited (ACL) and managed by a chief executive who is supported by a clinical manager and a nurse manager. Families and residents spoke positively about the care provided.

This surveillance 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 identified as requiring improvement. Improvements have been made to advance directives, internal audit, corrective actions, dementia unit staff training, documentation within care plans in particular behaviour monitoring and wound care, restraint risk assessments and restraint evaluation, which address those areas requiring improvement at the previous audit.

Consumer rights

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

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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A quality improvement and business goals plan 2016 - 2019 includes the mission statement, philosophy of care and goals of Age Care Central Limited (ACL). Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages 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 were current and reviewed regularly, by the CEO and designated senior staff.

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.

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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Residents of Maryann Rest Home and Hospital have their needs assessed by the multidisciplinary team on admission within the required timeframes. Verbal handovers and electronic handover reports guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Acute care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

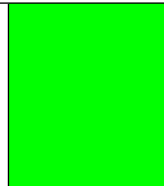
The planned activity programme is overseen by an activities coordinator and an activities assistant with oversight from a diversional therapist. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available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

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen has been recently upgraded, was well organised, clean and meets food safety standards. Residents verified overall 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.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required.

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. No enablers were in use at the time of audit. Two restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. 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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Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	20	0	0	0	0	0
Criteria	0	44	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 1.1.10: 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	Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent was defined and documented, as relevant, in the residents' records. Residents in the dementia unit had documented EPOAs on file. Advance directives were seen to be current and the need for this was understood by staff interviewed. The previous corrective action request (CAR) has been addressed.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The ACL complaints and concerns policy, flowchart and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is readily available throughout the facility and is provided to residents and families on admission. Those interviewed knew how to do so. The complaints register reviewed showed that four complaints have been received this year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The chief executive officer confirmed he is ultimately responsible for complaints management and follow up and that this is done in

		<p>conjunction with the relevant clinical or non-clinical manager. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</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>Clinical staff reported that they inform family members of any changes following medical review and should an incident occur. 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 through the local DHB, or family members although reported this was rarely required due to residents being able to speak English.</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>	FA	<p>The quality improvement and business goals plan 2016 - 2019, outlines the mission, philosophy and goals of the entire organisation. The document describes annual and longer-term objectives and includes associated operational plans. Annual progress against the objectives was most recently reviewed in December 2017. A sample of management meeting minutes showed adequate information to monitor performance is reported including but not limited to; bed occupancy, financial performance, staffing, training, emerging risks and issues. Managers' quarterly reports to the CEO are provided to the board of trustees as part of the board meetings as indicated in the board minutes sighted.</p> <p>The service is managed, along with Marire Rest Home by a CEO, a nurse manager and a clinical manager who hold relevant qualifications. The nurse manager and the clinical manager have been in their roles for two and a half years. These registered nurses share clinical management responsibilities, are based at this facility and work a total of 60 hours per week between them, across both sites. The facilities are situated only two kilometres away from each other. Responsibilities and accountabilities are defined in their job descriptions and individual employment agreements. The CEO, nurse manager, clinical manager and clinical coordinator confirmed knowledge of the sector, regulatory and reporting requirements. The CEO maintains currency in his role as deputy chair of Taranaki District Hospital Board, and through membership of the Aged Care Association. The nurse managers maintain professional knowledge through ongoing education including the Ko Awatea online learning, Taranaki DHB Leadership in Aged Care forum attendance and hospice training.</p> <p>The service holds contracts with the Ministry of Health (MOH) for Young Persons with Physical Disabilities (YPD) and the Taranaki DHB for dementia services and chronic long-term conditions, including for respite and age related residential care (ARRC). Two people were receiving services under the MOH YPD contract; one person was in the rest home and the other in the hospital. 15 people residing in the dementia unit were</p>

		<p>receiving dementia services under the DHB ARRC contract, 19 people were receiving services in the hospital and eight residents were receiving services in the rest home under the DHB ARRC contract. No one was accessing residential respite at the time of audit.</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>ACL has a planned quality and risk system, used at Maryann Residential Care Home and Hospital, that reflects the principles of continuous quality improvement. This includes management of incidents, concerns and complaints, audit activities, a regular resident and family satisfaction survey, monitoring of outcomes, including restraint use, clinical incidents including infections, skin tears, falls, medication errors and any other resident or staff related adverse events.</p> <p>Analysis monitoring, trending and reporting of clinical indicators is completed by the clinical coordinator and provided to staff within the electronic system. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting, health and safety and risk team meetings, RN and restraint group meetings, health care assistant (HCA) meetings, team meetings and residents' meetings. Staff reported their involvement in and awareness of quality and risk management activities through meeting attendance and audit activity. Internal audits have been completed as required by the internal audit programme. The corrective action from the previous audit relating to the internal audit schedule the analysis of data and the communication of results to staff has been addressed.</p> <p>Any identified shortfalls result in relevant corrective actions being developed and implemented to address the issue. The up to date corrective action register indicated a timely resolution and sign off process has been imbedded. The corrective action from the previous audit relating to clinical corrective actions has been addressed.</p> <p>Resident and family satisfaction surveys are completed annually and the results are shared with staff and residents. The most recent families survey in April this year showed overall satisfaction by ten of eleven respondents. Verbatim comments included 'I really appreciate the way staff take a personal interest in my relative', and 'I find the staff very pleasant and able'. Areas for improvement were identified by four respondents, regarding the range of activities offered, which has been addressed by the activities staff.</p> <p>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. The CEO, clinical manager, nurse manager and senior staff are each delegated responsibility for specific organisation wide policies and procedures.</p> <p>The CEO described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The CEO reported he is familiar with the Health and Safety at Work Act (2015) and has implemented requirements in conjunction with the domestic services supervisor.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff 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. Adverse event data is collated, analysed and reported to each of the regular staff meetings, the management meetings, and the board and directly to all staff through the electronic notification system.</p> <p>The CEO and clinical managers described essential notification reporting requirements (Section 31 notifications), including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>ACL 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. RNs reported they had a preceptor, and care staff reported that they had a 'buddy' to assist them. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and regular performance reviews.</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. An external person is the assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education and the corrective action from the previous audit regarding this has been addressed. There are sufficient 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 reviews.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and</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 senior staff and managers adjust staffing levels to meet the changing needs of residents. An after-hours 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</p>

<p>safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>available to complete the work allocated to them. Residents and family interviewed supported this. 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 24/7 RN coverage in the hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included 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 was consistently recorded on the electronic medicine chart.</p> <p>There were no 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>Medication errors are reported to the clinical co-ordinator and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Maryann Rest Home and Hospital.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And</p>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in July 2018.</p>

<p>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>Recommendations made at that time have been implemented and verified by the dietician.</p> <p>A food control plan is in place and registered with the Stratford District Council on 14 June 2018. A verification audit was undertaken on 17 August 2018. Recommendations made at the audit have been verified as being addressed.</p> <p>The kitchen has recently been upgraded with new chillers and appliances now operating. The kitchen was spacious, and well equipped to respond to increasing demands. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants 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.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents of the rest home have a choice of dining rooms to eat their meal. All generally choose to eat their meal in the hospital dining room. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Gentle pleasant music reflective of residents' likes, was playing in the background, enhancing a relaxed atmosphere for residents to eat their meal. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> <p>Residents in the secure unit have access to food at all times of the day</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care 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. Photographs evidenced improvements in wounds, no evidence of weight loss in the files reviewed was noted, and behaviour monitoring charts evidenced effectiveness with management strategies. The findings verified a previous corrective action request around interventions to manage behaviours and wounds, and timely review of wound monitoring, has been addressed. The facility was observed to be calm. Staff were observed to be responsive, happy and respectful. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. Specialist services voiced a high regard for the services provided. 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>	<p>FA</p>	<p>The activities programme is provided by a recreation co-ordinator who has nearly finished the diversional therapy training, and a recreation assistant. The programme is overseen by a trained diversional therapist and operates every day of the week. The recreation co-ordinator, who manages the programme was unavailable on the day of audit. Interview regarding activities was with the recreation assistant.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Notations in the resident's activity plan are made twice a day and enable ongoing assessment regarding the resident's participation. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. A range of community groups congregate at Maryann Rest Home and Hospital enabling residents to continue participating in these community groups and mixing with friends. Several residents walk into town, bike around town or use mobility scooters to get out and about. A facility van is available for outings.</p> <p>There are activities provided for residents of the secure unit, seven days a week. While a programme is planned, it is flexible and adaptable to the daily needs of the residents. On some days the residents from the unit join the activity sessions in the hospital/rest home. This is particularly occurring during the monthly themed events and days when visiting groups are at the facility. Residents in the secure unit and other residents with dementia, have a twenty-four-hour activity plan in their care plan that identifies the activities that suit the resident at certain times of the day.</p> <p>The activities programme is discussed at the minute residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of acute care plans being consistently reviewed and progress evaluated as clinically indicated and according to the degree of</p>

manner.		risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness, expiry date 1 May 2019, is publicly displayed in the main reception.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>Surveillance of infections is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. Infections are diagnosed by the GP. When an infection is identified, an infection form is filled out in the resident's electronic care plan. Interventions are put in place, and an infection alert highlights the infection, until it is recorded as resolved. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via the electronic care management system, staff meetings and at staff handovers. Surveillance data is carried over into in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>Policies and procedures provide guidance on the safe use of both restraints and enablers. The clinical coordinator who performs the role of restraint coordinator provides support and oversight for enabler and restraint management in this facility. She demonstrated a sound understanding of ACL's policies, procedures and practices. The restraint coordinator was also aware of and her role and responsibilities regarding restraint practices and expressed a strong desire to have a restraint free facility, giving examples of trials to remove the current restraints.</p> <p>On the day of audit, two residents were using a restraint in the form of padded bedrails. No residents were using enablers. Staff described enablers as being the least restrictive and used voluntarily at a resident's</p>

		<p>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 evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Click here to enter text</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented within the electronic residents' files and included all requirements of the Standard. An RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA as relevant. The restraint coordinator and staff described the documented process. Families' involvement was confirmed in the residents' files. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. This documentation of risk within the care plan addressed the corrective action from the previous audit. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of the two residents who were using a restraint.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' electronic files and restraint meeting minutes showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Staff interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options and past attempts to eliminate</p>

		use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. Improvements have been made following the previous audit to ensure evaluation of restraints used addresses all aspect of the criterion.
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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.