Heritage Lifecare (BPA) Limited - Elizabeth R

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:	Heritage Lifecare (BPA) Limited
Premises audited:	Elizabeth R
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 January 2019 End date: 16 January 2019

Proposed changes to current services (if any): In October 2018 the facility applied to Ministry of Health to reconfigure the current service to increase the dual rest home/hospital beds to 19 and to have 19 rest home level beds. This was approved with Elizabeth R Life care with a request for these changes to be followed up at the next audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 29

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Elizabeth R Lifecare provides rest home and hospital level care for up to 38 residents. The service is operated by Heritage Lifecare (BPA) Limited (HLL) and managed by a facility manager and a clinical services manager. The facility has been completely re-clad and externally painted since the previous audit. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contracts with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, management and staff, contracted health providers and a general medical practitioner. In addition the recent re configuration of beds met requirements.

There were no areas identified as requiring improvement.

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.

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.

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. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvements data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented and 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.

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.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident and 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.

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. 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 products and the laundry service is evaluated for effectiveness.

Staff are trained in emergency management 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.

Elizabeth R Lifecare has implemented policies and procedures that support the minimisation of restraint. One enabler and two restraints were in use at the time of audit. An 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

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

The infection 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	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The 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 provided relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. At the time of admission, a discussion is had with the resident and family regarding advance directives. Staff were observed to gain consent for day to day care.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	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 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. The residents at the facility are also supported by an independent advocate who lives locally in the community, is available as required and attends the three-monthly residents' meetings. The contact details of the advocate are clearly displayed on several notice boards throughout the facility.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents 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, entertainment and interacting with the other local facilities. 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.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints and concerns policy which meets the requirements of Right 10 of the Code. There is a flowchart associated with the policy to assist staff in understanding the process for complaints management. The information is provided to residents and their families on admission and there is information and forms available in the information pack and forms were sighted in all service areas of the facility. The complaints register reviewed showed that two complaints have been received over the past year and that actions were taken through to an agreed resolution. Appropriate timeframes specified in the Code were effectively met. Action plans reviewed showed any required follow-up and improvements have been made where possible. The facility 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. The facility manager reported that there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, the District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.
Standard 1.1.2: Consumer Rights During Service	FA	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

Delivery Consumers are informed of their rights.		staff. The Code is displayed in at the main reception area together with information on advocacy services, how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room with two couples having consented to sharing a room. All residents have easy access to the main garden, two main lounges and several small sitting alcoves. Residents are encouraged to maintain their independence by personalizing their own rooms, attending community activities, participation in clubs of their choosing and arranging their own visits to the doctor. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. 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. 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.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	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 clinical services manager interviewed reported that there are two residents who affiliates with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is an individual Maori health plan and all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and evidenced and integrated into long-term care plans with input from cultural advisers within the local community as required. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. A resident that affiliates with their Maori culture and their whanau interviewed stated that they were very happy with the care provided and reported that staff acknowledge and respect their individual cultural needs.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	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, for example, the attending of church services. The resident satisfaction survey confirmed that individual needs are being met.

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, dietician, physiotherapist, podiatrist, gerontology nurse 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. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included the acknowledging and welcoming of residents' visitors, knocking on residents' doors before entering, and day to day conversations/discussions between residents, staff and visitors.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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. Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. There were two residents acknowledged with a significant sensory impairment and appropriate equipment and resources were sighted and highlighted in the residents' long-term care plans reviewed, for example, providing clear conversation, supporting of yes or no answers to questions with staff allowing time for the resident to respond, support from external services, for example, speech language

		therapist and required equipment.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The business plan 2018-2019, which is reviewed annually, outlines the purpose, values, scope, direction and objectives of the organisation. The facility manager and the clinical services manager at Elizabeth R Lifecare also develop site specific objectives which link with the quality plan objectives. The documents reviewed described annual and longer-term objectives and the associated action plan. The facility manager provides weekly reports on occupancy, health and safety, complaints and compliance issues (incidents/accidents), new risks identified and/or any outstanding issues. The clinical services manager interviewed provides monthly reports to Heritage Lifecare (BPA) Limited (HLL) directly to the national quality compliance manager (NQCM) including all clinical indicators and any other relevant clinical information. The information provided includes falls with and without injury, pressure injuries, infection rates and the narrative reports and data reports. The clinical services manager collates the information and provides all information in graph form prior to forwarding directly to the General Manager clinical and quality. Prior to reporting to the GM clinical and quality the clinical services manager reports the results to the facility manager and the staff directly. If any trends are identified at this stage a corrective action form is completed and actioned as soon as possible. The service philosophy is in an understandable form and is available to residents and family/representatives or other services involved in referring residents to the service. It is also documented in the information pack provided and reviewed. The service is managed by a facility manager who holds relevant qualifications and is experienced in the aged care sector. The facility manager is a qualified enrolled nurse with a current annual practising certificate and holds a Diploma of Health Studies in Gerontology and has been in this role for five years. The facility manager has attended relevant business management and aged care related conferences and study days and is supported by the clinical services manager and staff at the support office for Heritage Lifecare (BPA) Limited (HLL). The service holds contracts with the district health board (DHB) for hospital residential care medical and geriatric, rest home residential care and respite care services. The service has thirty eight (38) beds available. There are a total of 19 dual beds (hospital/rest home) and 19 rest home beds as from 08 October 2018 when a configuration of beds was approved by the Ministry of Health. A letter sighted verified these changes had occurred. On the day of audit there were 29 residents; 15 rest home, 13 hospital and one resident receiving respite care (hospital level of care).
Standard 1.2.2: Service Management	FA	When the facility manager is absent, the clinical services manager (who has been in this position for six months) carries out all the required duties under delegated authority. Support is also provided from HLL at all times. During absences of key clinical staff, the clinical management is overseen by a registered nurse with

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.		support from personnel from HLL support office. Staff reported the current arrangements work well.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by the staff. This includes management of incidents/accidents, complaints and audit activities, an annual satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint minimisation and safe practice. Terms of reference and meeting minutes sighted confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs, and related information is reported and discussed at the weekly team meetings, and quality and staff meetings held monthly. Minutes reviewed included discussion on pressure injuries, restraints, falls, complaints, incident/adverse events, infections, audit results and the activities programme. Staff interviewed reported their involvement in quality and risk activities through audit activities, for example, for the laundry and the kitchen. Any relevant corrective actions are developed and implemented as necessary to demonstrate continuous improvement is occurring. Resident and family surveys are completed annually and are sent out from the HLL support office. The last survey was completed in April 2018. The facility manager commented that there had been a smooth transition after the change of ownership, across all areas of service delivery. Policies reviewed covered all necessary aspects of the service and contractual requirements and were current. The document control system is managed at HLL support office by the NQCM and quality team. All documents are updated as required and sent out via a memorandum with instructions for replacement in the manuals. The facility manager sends back a declaration that the documents have been updated on site. The clinical and quality improvement lead for HLL was present at this audit to support the management and staff and verified the document control process and that the 2019 internal audit schedule for the organisation is currently being reviewed. The organisation wide process ensures a systematic and regular review process, referencing of relevant resources, approval, distribution and removal of obsolete documents. Staff are updated on any new policies or changes to policies through the staff meetings. The facility manager described the process for the identification, monitoring of risks and development of mitigation strategies. The risk register is updated at head office. The service risk register showed consistent review and updating of any risks identified, risk plans and the addition of any new risks. The facility manager and clinical services manager are aware of and have attended training in the Health and Safety at Work Act (2015) requirements and have implemented requirements. The clinical services manager is the health and

		safety coordinator/representative.
Standard 1.2.4: Adverse Event Reporting 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.	FA	The facility manager interviewed ensures any adverse event reported is dealt with immediately. Addressing incidents before they manifest into more significant events has proven to be valuable for the service. The aim of adverse event reporting was to close the 'quality loop' quickly and effectively. The incident management process is closely linked to the quality and risk management system. Evaluation of what corrective action has been developed and implemented and/or any trends identified are detected and improvements actioned quickly. An incident register is maintained. An incident/accident form audit was performed 29 November 2018. A sample of incident forms reviewed show these were fully completed, incidents were investigated, actioned and follow-up was completed in a timely manner. Adverse event data is collated, analysed and reported by the clinical services manager to the facility manager monthly and meeting minutes reviewed showed discussion in relation to any trends, action plans and improvements made. The facility manager interviewed described essential notification reporting requirements. The service has had five Section 31 notifications of significant events made to the Ministry of Health (MoH) since the previous audit. The Ministry of Health (MoH) was notified of the change of clinical services manager in a timely manner in July 2018.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Policies and procedures are in line with good employment practice and relevant legislation and guide human resources management processes. Position descriptions reviewed were current and defined key tasks and accountabilities for the various roles. The facility manager and the clinical services manager are responsible for the recruitment process which includes reference 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 systematically and well maintained. Employment checklists were used in the front of each individual staff record sighted. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed showed documentation of completed orientation and a performance review annually. Continuing education is planned on an annual basis. The in-service education calendar was sighted. Mandatory training requirements are defined and scheduled to occur over the course of the year. An education register has been developed and implemented for 2018 and 2019 and a record is maintained by the clinical services manager. Competencies are maintained and were recorded on the competency register reviewed. Care staff have completed the required education to meet the requirements of the provider's agreement with

		the DHB. Education records reviewed demonstrated completion of the required training. Seven of eight registered nurses have completed and are competent to perform interRAI assessments. All interRAI assessments were current and up-to-date. Time is allocated to the staff for completing the required assessments. Staff reported that the annual performance appraisal process provided an opportunity to discuss individual training needs and to review competencies. Appraisals were in progress at the time of audit. A plan for completing the staff appraisals was developed and implemented.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is 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 organisation (HLL) uses 'allocation of staff/duty rosters', an electronic tool based on indicators for safe staffing, and this is used by the facility manager and the clinical services manager when preparing the rosters There is a documented rationale for safe staffing. The facility manager can 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. The facility manager, clinical services manager and the unit co-ordinator cover the after-hours service. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and families interviewed supported this. The general practitioners (GPs) cover their individual residents in the day time hours Monday to Friday, however there is currently no GP after-hours service available. Staff interviewed stated that they were well informed of the after-hours procedure if required. The resident's family are contacted if and when required. The rosters reviewed confirmed adequate staff cover has been provided with staff replaced in unplanned absences. There is one registered nurse on duty on the morning, afternoon and night shift and Monday to Friday the facility manager and the clinical services manager are on site. There is adequate care staff to cover the facility on all shifts. The approved reconfiguration has had no impact on the staffing arrangements. Auxiliary staff, including the diversional therapist, the cook, kitchen hand and tea shift cover staff, were included on the rosters reviewed. The staff interviewed commented that any emergency situations are managed effectively. All staff have completed first aid courses and certificates were in the staff records reviewed. There are eight registered nurses and two enrolled nurses, including the facility manager and the clinical services manager. All have competencies for medication management, verification of death, wound care management, female and male catheterisation and other medical and palliative care management roles.
Standard 1.2.9: Consumer Information Management	FA	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

Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		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. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	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 GP for residents accessing respite care. 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 detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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 reviewed of a patient recently transferred to the local acute care facility showed documentation of clear communication between the facility, acute services and family.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management both and electronic and paper-based system was observed on the days 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. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks

guidelines.		medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. 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. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Residents are supported by five GPs from the local medical centre and three independent GPs. 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 reviews were up to date and consistently recorded on both the electronic and paper-based medication charts. Standing orders are not used. There is one resident who self-administered medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by one of two cooks, a relief cook and kitchen assistants, 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. All aspects of food procurement, production, preparation, transportation, storage, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Stratford District Council and expires 12 June 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have undertaken a safe relevant food handling qualification. 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. All meals are cooked on site and served directly to the residents in the adjacent dining room with the option of residents having meals in their rooms. 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.

Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently 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.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as a pain scale, incontinence assessment, falls risk, skin integrity, nutritional screening, depression scale and pressure injury risk, to identify any deficits and to inform care planning. A risk summary is completed at the time of admission and updated six monthly or sooner if changes occur for the resident. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of seven trained interRAI assessors on site which includes the clinical services manager. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	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 and were resident focussed. Care plans evidenced 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.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and	FA	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. The GP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. 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.

desired outcomes.		
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by an activities co-ordinator who supports the residents Monday to Friday from 9.00 am to 3.30 pm and has the support of a regular volunteer three days a week. 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 three monthly and as part of the formal six-monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and included 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, satisfaction surveys and day to day discussions. Residents interviewed confirmed they find the programme interactive and fun. Families interviewed stated that they are often invited to attend the events/functions being organised at the facility and enjoy being included.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. 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 skin tears, infections, wounds, and weight loss. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer	FA	Residents are supported to access or seek referral to other health and/or disability service providers. 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 a speech language therapist, physiotherapist, ophthalmology services and mental health services for older people. 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.

choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances were in place. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal. A contracted company removes all re-cycling and cardboard waste and normal waste is collected by the council weekly and as needed. There is a designated area for storing chemicals used for cleaning and the laundry which is securely locked. The room and all containers in use are clearly labelled. An external company is contracted to supply and manage chemicals and cleaning products and they also provide relevant training for staff. Material data sheets were available where chemicals are stored and used and staff interviewed knew what to do should any chemical spill/event occur. A spill kit was accessible. Any related incidents are reported in a timely manner. There is adequate provision and availability of protective clothing and equipment and staff were observed using this, including gloves, aprons and hats.
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 building warrant of fitness is current and was displayed at the entrance to the facility dated to expire 09 July 2019. Appropriate systems are in place to ensure the resident's physical environment and the facilities are fit for purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate and safe standard. The testing and tagging of equipment and calibration of medical equipment was current and confirmed in documentation reviewed, interviews with the maintenance person and observation of the environment. An equipment validation report was reviewed. All hoists are included in the checks and one oxygen concentrator is ready for use. The oxygen cylinders are stored appropriately on trollies in readiness near the facility manager's office on site. A process is in place for replacing and ordering if further supplies are required. The reconfiguration approved by the Ministry of Health in 2018 has not impacted on the equipment and resources required to support and meet the residents needs. The grounds are safely maintained and are appropriate to the resident groups and the setting. The environment is conducive to the range of activities undertaken. The environment was hazard free and residents were safe. Staff interviewed confirmed they knew the processes they should follow if any repairs or maintenance was required and that any requests are appropriately actioned. Residents reported they were happy with the environment.
Standard 1.4.3: Toilet,	FA	There is a mix of toilet, showers and bathing facilities. This includes rooms with ensuites (one wing) and

Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		shared communal bathrooms in close proximity to the residents' rooms. All individual resident's rooms have a hand basin. Appropriately secured and approved handrails are provided in the toilet/shower areas and other equipment/accessories are available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate space provided to allow residents and staff to move around within the bedrooms safely. All bedrooms provide single accommodation. All rooms are personalised with furnishings, photographs and other personal items being displayed. There are recessed areas to store mobility aids, walking frames and wheelchairs. Staff and residents interviewed reported the adequacy of bedrooms. Hoists sighted were stored in a designated area and did not impede walkways or create a hazard for mobile residents.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are two communal lounge available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. One small recessed area is in a sunny position and has seating for two residents. Furniture is appropriate to the setting and residents' needs are met. The furniture in the dining room and lounges is arranged in a manner which enables residents to mobilise freely.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic	FA	All laundry is undertaken on site in one dedicated laundry. Facilities were readily available in the laundry sighted. Resident's personal laundry items are laundered on site or by family members if requested. Residents and family members interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently washed by the care staff and time is allocated to undertake this responsibility. The staff interviewed had good knowledge of the laundry processes, managing soiled linen and

cleaning and laundry services appropriate to the setting in which the service is being provided.		the clean and dirty designated boundaries in the laundry. The maintenance person ensured the lint was removed three times a day from the clothes driers when in use. Staff knew to do this in the absence of the maintenance person. After hours the care staff continue the laundry duties as able. There are designated cleaners who are fully trained, including training on infection control, products and protocols. The cleaners cover the total facility. Material data sheets are available for all products in use. A chemical spills kit is available if and when needed. The maintenance person is responsible for maintaining and checking of the hot water temperatures in all service areas including the kitchen and the laundry. The cleaning trolley is stored appropriately when not in use in one of the locked sluice rooms. Chemicals are refillable, and all containers used were adequately labelled. Cleaning and laundry processes are monitored through the internal audit programme and by the company representatives.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning duties direct the facility in their preparation for disasters and described the procedures to be followed in the event of fire or other emergencies. A flow chart was reviewed. The current fire evacuation plan was approved by the New Zealand Fire Service, the most recent being the 14 April 2016. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent being the 05 December 2018. There was good attendance and documented of staff who attended. The local fire service attends the fire drills and provides feedback to the staff. The staff orientation programme includes fire and security training. Staff interviewed confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency are available and includes adequate water supplies as recommended for the Taranaki region. Food supplies are available to meet requirements for up to three days. Blankets, mobile phones, torches, lanterns and gas barbecues were sighted and meet the requirements for a maximum of thirty eight (38) residents. The emergency lighting which is regularly checked and lasts approximately three to four hours. The service does not have a generator but is prioritised in the region for energy power supply as soon as available. Emergency protocols are linked with the DHB and Hawera Hospital if required and contact details of other aged care providers are accessible in the event of an emergency in this region. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families interviewed reported staff respond promptly to call bells. The service transport van, which is checked regularly and serviced, has a current warrant of fitness (expiry 20 May 2019) and the registration is current (expiring 31 March 2019). A first aid kit is always kept in the van and is checked regularly. Security arrangements are in place and staff ensure all doors and windows are locked at a predetermined time in the evening and are again checked by the night staff routinely. A night outside security light has been

		installed recently after an incident in the grounds involving a staff member. A section 31 notice was completed and additional improvements have been made in this area.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' individual rooms and communal areas have opening external windows with natural light. Gas heating is provided throughout the facility. Additional electric heaters are available in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facility is maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service implements an infection prevention and control (IPC) programme to minimises the risk of infections to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the GP's, gerontology nurse specialist, district nurses and infection control team at the district health board. The infection control programme and manual are reviewed annually. 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 facility manager, and tabled at the registered staff and quality meeting. The infection prevention and control policy states that in the event of an infectious outbreak, signage will be placed at the main entrance to the facility requesting 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 they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for five years. She has undertaken regular 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. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. At the time of audit, three individual infection outbreak kits were sighted throughout the facility.

meet the needs of the organisation.		Each kit has a checklist which is reviewed monthly by the infection control nurse.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standards and current accepted good practice. Policies were last reviewed in March 2018 and included appropriate referencing. 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.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	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. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.
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	FA	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 regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the clinical services manager and reported to the facility manager. Nineteen residents and 17 staff consented to the flu vaccine in April 2018. The facility has had a total of 45 infections since July 2018 through to and including December 2018. Three residents have been identified with 10 of those 45 infections due to co-morbidities. Two of the three residents have since deceased. The remaining one resident's file reviewed highlighted short term and long-term care

programme.		planning to reduce and minimise the risk of infection. It was noted at the time of audit that over reporting of infections is occurring. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked externally within the group monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. The infection control nurse interviewed stated that the facility has had no outbreaks over the last 12 months.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. A flow chart is also available to guide staff. The restraint coordinator, a registered nurse, was not available for the audit but provides support and oversight for enabler and restraint management in the facility when required. The facility manager interviewed demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities. On the days of audit, two residents were using restraints. One resident was using an enabler which was the least restrictive and used in a voluntary capacity at the request of the resident. Restraint is only used as a last resort when all alternatives have been explored. This was clear on review of the restraint approval group minutes and records reviewed and staff interviewed.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval group made up of the general practitioner (GP), the facility manager, the clinical services manager and the restraint coordinator (RN) are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of the restraint approval group meeting minutes, residents' records and interviews with the facility manager that there were clear lines of accountability,that all restraints have been approved and the overall use of restraints is being monitored and analysed. Evidence of family/whanau involvement in the decision making was on file in each case. Use of restraint or an enabler is part of the plan of care.
Standard 2.2.2: Assessment	FA	Assessments for the use of restraint were documented and included the requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement and input from the resident's

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.		family. The facility manager interviewed described the documented process. Families confirmed their involvement. The general practitioner is involved with 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. 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.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised and the facility manager interviewed described how alternatives to restraints are discussed with staff and family members. When restraint is in use frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register is maintained and updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record. Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff interviewed understood that the use of restraint is to be minimised and how to maintain safety when in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' records showed that the individual use of restraints is reviewed and evaluated during interRAI and care plan reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed involvement in the evaluation process and their satisfaction with the restraint process. The evaluations cover all requirements of the Standard including future options to eliminate use, the impact and outcomes achieved and if the policy and procedure was followed and documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint approval committee undertakes six monthly review of all restraint use which includes all the requirements of this standard. Six monthly restraint meetings and reports are completed and individual use of restraint is reported to the staff and quality meetings. Minutes of meetings were reviewed and confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the GP, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the facility manager

		confirmed that the use of restraint is minimised.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.