

Experion Care NZ Limited - Greendale Residential Care

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 Q-Audit 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:	Experion Care NZ Limited		
Premises audited:	Greendale Residential Care		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 30 January 2019	End date: 31 January 2019	
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: 25			

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

Greendale Residential Care is an aged care facility owned by Experion Care NZ Limited. The service provides rest home level care and holds mental health; respite; and LTS-CHC contracts. On the day of the audit there were 25 residents. There have been no changes in the management team since the last audit. However, the clinical manager has resigned and finished on the last day of the audit.

This certification audit was conducted against the Health and Disability Services Standards and the service contract of the district health board (DHB). The audit process included review of policies and procedures, review of residents and staff files, observations and interviews with residents, families, management, staff and general practitioners.

The four previous areas requiring improvement have been addressed and maintained. There are two areas for improvement identified during this audit relating to assessments following unwitnessed falls, and evaluation of episodes of restraint.

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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Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. Information is provided to residents and their families on entry to the service and when requested. Residents and family members confirmed their rights are met, staff are respectful of their needs and communication is appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Written consent is gained as required. Residents and family members are provided with information prior to giving informed consent and time is provided if any discussions and explanation are required.

Care is guided by a Maori health care plan and other related policies. Links with family/whanau and the community are encouraged and supported by the service provider

Staff receive regular and ongoing training on resident rights and how these should be implemented on a daily basis. Services are provided that respect the independence, personal privacy, individual needs and dignity of residents. All aspects of service delivery are consistent with upholding and respecting residents' rights.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination or abuse and neglect, with these policies are understood by staff. Professional boundaries are understood by staff and maintained.

The complaints process is included in the resident information book. Forms and drop box are provided in the foyer. All concerns are taken seriously and dealt with promptly. There is evidence of open communication with residents and families.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation is governed by an off-shore owner who owns four residential rest homes in New Zealand. An experienced nurse manager is responsible for overall management of the facility and closely monitors organisational performance. Detailed monthly reports are provided to the owner. An experienced registered nurse is responsible for the daily operational management of clinical care.

There is a documented quality and risk management system that is appropriate to the size of the facility and the level of care provided. Internal quality audits are scheduled and implemented. Quality data is collated monthly and used to improve the services. Policies and procedures are current and individualized to the facility. All adverse events are documented, investigated and closed in a timely manner. Clinical indicators, quality and risk issues and discussion of any trends identified are presented at quality/staff meetings and reported to the owner.

There are processes for identification, rating and treatment of actual and potential risks including those associated with human resource management, legislative compliance, contractual risks and clinical risk. There is a hazard register that is kept up to date. A health and safety policy is in place and staff training is provided.

There are appropriate policies and procedures on human resource management. Current annual practising certificates for health professionals who require them are retained. New staff receive a detailed orientation and a monthly in-service education programme is provided for staff. There is a documented rationale for determining staffing levels and skill mixes that meets

contractual requirements. The managers are rostered on call after hours. All care staff interviewed report there is adequate staff available.

A paper-based resident information system and a register are maintained in a timely manner. Resident records are integrated. Entries in residents' clinical records are legible, timely and designated to the care provider. Access to resident information is protected and the privacy and security of resident information are maintained.

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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The admission process is managed by the clinical manager (CM) and the nurse manager (NM). The general practitioners (GPs) are involved in the admission process and three-monthly reviews of medications or as required. Residents' medical admission is completed in a timely manner. The nursing team is responsible for developing the care plans. Care plans and interRAI assessments are completed in a timely manner.

Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There are policies and procedures that clearly document the service providers responsibilities in relation to each stage of medicine management. All medication administration competencies are current. The service uses a pre-packaged medication system that is paper based.

Food, fluid and nutritional needs of residents are provided in line with the recognised nutritional guidelines appropriate to the residents' needs.

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.

There have been no changes to the facility since the last audit. There is a current building warrant of fitness and approved fire evacuation plan. A preventative and reactive maintenance programme includes annual equipment calibration and electrical checks.

There are single and double bedrooms. Residents' rooms have adequate personal space provided. There sufficient toilets and showers for the number of residents. There are two lounges and one dining area available. An appropriate call bell system is available and security and emergency systems are in place. Fire education and trial evacuations are held twice a year. All staff have attended at least once in the last 12 months. There are sufficient staff with first aid training to cover all shifts.

Waste management, cleaning and laundry processes meet regulatory requirements. All laundry is washed on site. Cleaning and laundry audits are used to evaluate the effectiveness of these services. Suitable appliances and protective clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored.

All resident rooms have windows providing natural light. An internal heating / cooling system maintains comfortable temperatures all year round. Access to external areas is level and paved. Shade and seating are provided.

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.		Some standards applicable to this service partially attained and of low risk.
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There are clear and comprehensive documented policies and guidelines on the use of restraints, enablers and management of challenging behaviours. There are no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated an understanding of restraint and enabler use and receive ongoing restraint education.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme is developed in consultation with the relevant key stakeholders. The environment is managed in a way that minimises the risk of infection to residents, staff and visitors. Staff receive infection control education during orientation and annually thereafter. The NM is the infection control coordinator and is responsible for monitoring infections, surveillance of data, trends and implementing relevant strategies. There have been no infection outbreaks reported since the last audit.

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	47	0	2	1	0	0
Criteria	0	98	0	2	1	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	There are policies and procedures in place to ensure residents' rights are respected by staff. Interviewed staff demonstrated knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the staff training education programmes. On the days of the audit, staff demonstrated knowledge of the Code when interacting with residents. The residents and family/whānau reported that staff respect their rights and are incorporated as part of their everyday practice.
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	Policies and procedures on consent support the residents' right to make informed decisions. The CM reported that informed consent is discussed and recorded at the time the resident is admitted. The residents' files sampled had the required consent forms signed by residents and where appropriate, by the enduring power of attorney (EPOA). The policy references Rights 5, 6 and 7 of the Code and the process for determining competency and advanced directives. Staff acknowledged the residents' right to make choices based on information presented to them. Family/whānau interviewed confirmed that residents were provided with day to day choices and consent was obtained. The GPs' interviewed reported satisfaction with communication from staff.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>There were appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. The advocacy policy details contact information for the Health and Disability Commission and Age Concern advocacy services. Information about the right to advocacy and contact details for local services is included in the information given and explained to residents and families on admission. Staff training on the right to advocacy/support is provided annually and staff demonstrated an understanding of how residents can access advocacy/support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and relatives are encouraged to visit at any time. Residents and family/whānau reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a detailed complaints process set out in policy. The process provides details of how to make a complaint, how to access advocacy services or make a complaint to the Health and Disability Commission (HDC) and refers to Right 10 of the Code.</p> <p>The complaints process is also outlined in the residents' handbook and in the admission agreement. Complaint forms are available at the front desk along with information on advocacy services available. In the entrance area posters of the Code are displayed in both English and Maori.</p> <p>A complaints register is maintained for both verbal and written concerns. The register and associated records provide evidence that complaints are dealt with in the time frames set out in policy. The nurse manager (NM) is responsible for the complaints and responding in writing. Meeting minutes sampled and staff interviewed confirmed that any findings are part of feedback both at the staff meetings and the residents' meetings. The information is used to form part of the quality process. Records reviewed and staff interviews confirmed that staff are educated about the complaints process in orientation and through internal training. Residents / families interviewed confirmed that they felt able to raise concerns with staff and that the managers responded promptly. Residents stated in interview that they raise issues at their meetings, and they are dealt with.</p> <p>It was reported that there have been no investigations by HDC, Ministry of Health (MoH), the Accident Compensation Commission (ACC) police or coroner since the last audit</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information about the Code and the Nationwide Health and Disability Advocacy Services is displayed in the facility. The clinical manager (CM) reported that an advocate visits the service and can be accessed as required.</p> <p>Residents and family/whanau interviewed were aware of their rights and confirmed that information was provided to them during the admission process. The resident information handbook was sighted and outlines the services offered. Signed residents' agreements were sighted and meet the requirements of this standard and district health board requirements.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The privacy and dignity policy explain how staff are to ensure the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents' related information. The process for accessing personal health information is detailed. The care planning process identifies and records interventions for respecting residents' individual beliefs and values. The service has single and shared rooms in which physical, visual, auditory and personal privacy are maintained. Residents' personal belongings are maintained in a secure manner. There are documented policies and procedures on abuse and neglect including the required reporting process. Relevant education has been provided to staff in the last two years.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Care and services for Maori consumers are covered by the four dimensions of Te Whare Tapa Wha which are mental, physical, whanau and spiritual wellbeing. The Maori perspective on health is documented and includes Maori models of health and barriers to access. Terminal care and death of the Maori resident is included. Cultural needs are included in the care plans (if identified). There is access to cultural advice, resources and documented procedures to ensure recognition of Maori values and beliefs. There were no residents who identified as Maori. The organisation maintains contact with local Iwi. Cultural safety training is provided to all staff. The Code is available in Maori and satisfaction surveys include cultural and spiritual beliefs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual</p>	FA	<p>Cultural needs are determined on admission and a management plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the principles of the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident. Residents' values and beliefs are discussed and incorporated into the care plan. Residents and family/whanau members interviewed confirmed they are encouraged to be involved in the development of resident lifestyle care plans. In interviews conducted, staff demonstrated an</p>

values, and beliefs.		understanding of cultural safety in relation to care.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Care and services are available to all residents requiring residential care provided by the facility without discrimination or prejudice. Policies sighted evidence processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation. The staff code of conduct and professional behaviour is included in the employment and orientation process. Staff demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and family/whanau reported that staff maintain appropriate professional boundaries. The CM demonstrated awareness of the importance of maintaining professional boundaries and processes they are required to adhere to.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	There are systems in place to ensure staff receive a wide range of opportunities which promote good practice. Staff reported that they were satisfied with the relevance of the education provided and were able to explain how they maintain good practice. Policies and procedures are linked to evidence-based practice and treatment protocols. There are regular visits by the GPs and allied health providers as required. The nursing team is available and accessible to care staff for clinical support and advice when required. DHB clinical advisers are accessed as needed.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	Staff education has been provided related to appropriate communication methods. The service has required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed. Documentation regarding open disclosure following incidents/accidents was evident. Residents and family/whanau reported that they are informed of any events or concerns. Contact with families/carers is documented in resident records. The GPs' interviewed reported satisfaction with communication from staff.
<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	Greendale Residential Care is one of a group of rest homes owned by Experion Care NZ Ltd. The rest home was purchased in March 2016 and the current NM is responsible for the overall running of the home and has been in the role since January 2017. The clinical manager (CM) oversees the day to day running of the home with support from the NM who also manages one of the other homes in the group. The CM has been in the role since March 2017. The CM has submitted their resignation and their last day was January 31, 2019. The NM and CM are both registered nurses. They work closely together and provide 24/7 nurse cover. The NM reports to the owner monthly using a

		<p>comprehensive quality management report and more frequently if needed. Both RNs have detailed position descriptions and current practicing certificates. Individual personnel records indicate they have both maintained required management and clinical training hours.</p> <p>The organisation vision and mission statement are identified in the quality manual, the business plan, the residents' handbook and on the wall in the foyer. The documents were revised and coordinated in 2018. Residents and their families are made aware of the vision and mission in the handbook. The strategic plan is current and reviewed annually to ensure the services offered meet the needs of the residents and is monitored through the monthly report to the owner.</p> <p>The organisation is certified to provide age-related rest home care and holds additional residential contracts with the district health board for the provision of mental health residential care, long-term support, young disabled care and respite care. The home has capacity for 27 residents. On the day of the audit there were 25 residents in the facility: 22 were aged care, one accessing long term support under LTS-CHC contract and two residents under the mental health contract. One of the mental health residents and the resident on LTS-CHC contract were both less than 65 years of age.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager oversees the day to day running of the home with support from the NM. The NM and CM are both registered nurses. They work closely together and provide 24/7 nurse cover. The CM deputises for the NM in their absence with back up from the NM of another facility in the Experion group. The manager reported a senior carer is in charge after hours with the NM or the CM on call. Position descriptions and staff interviews confirmed their responsibility and authority for these roles.</p> <p>Review of service delivery indicated that services provided meet the specific needs of the resident group within the facility.</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>	FA	<p>There is a documented business quality and risk management plan dated 2018 - 2020. The plan sets quality goals and outlines action plans. Risks, responsibilities and controls are identified. Quality and risk are integrated into the business plan and other organisational systems including incident/accident process; complaints system; infection control and the health and safety system. The plan is formally reviewed biennially. Staff interviewed confirmed that they understand the quality system and that they are provided with the comprehensive monthly quality management report that is sent to the owner. Other less formal communication is undertaken by the NM and the owner via email and telephone.</p> <p>The internal audit system was sampled and results from 2018 were sighted. The information from</p>

		<p>internal audits is reported in the monthly quality management report. Service shortfalls are identified and monitored until the required threshold is met. Areas for improvement that are identified are either managed through the staff, resident or manager meeting systems, where the corrective action is documented in the minutes and signed off at the next meeting or transferred to a corrective action form. The data from internal audits is bench marked against the indicator used in each facility in the group.</p> <p>Policies and procedures are individualised to the facility and made available to staff in the nurses' station. All policies and procedures sampled met current compliance requirements and were in accord with current best practice. The document control process is clear and integrated into the quality system. Evidence of updating documents was viewed. Staff sign when they have read a new document. Obsolete documents are removed from circulation.</p> <p>Key components for service delivery are linked to the quality system and are standing agenda items in the monthly meetings. These include health, safety and hazards, adverse events, complaints, staffing, resident care, falls, complaints and compliments, infection control. There is evidence that action is taken to correct problems and unwanted trends and prevent recurrence. In interviews staff, family/whānau and residents confirmed that they are comfortable raising any issues, including newly identified actual and potential hazards, with the management and that issues are addressed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>A register of adverse event is maintained. There is a system for reporting and managing adverse events. Staff record adverse, unplanned or untoward events on an incident / accident form. The NM collects information required and analyses the data and this data is reported at the monthly meetings and compared to other months data. Information is used to feed into the quality system and improvements made. Management are aware of the statutory requirements for reporting. No reports have been made since the last audit.</p> <p>Accidents/ incidents were sampled from the register. These confirmed that families were informed, and events closed off in a timely manner. Improvement is required to ensure that appropriate observations are consistently undertaken following a fall. Staff interviewed confirmed their understanding of the process and the need to report. Residents and families confirmed in interview that the process was understood and easy to use.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>Human resource policies and procedures are in place and support good practice. There is a defined recruitment process which validates professional qualifications and police checking. The NM is</p>

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		<p>responsible for undertaking the recruitment processes and the owner signs off appointments. Detailed position descriptions are outlined for each role.</p> <p>All staff employed since Greendale was brought by Experion Care Limited have received orientation. This includes all essential components of service delivery including emergency management. Staff files reviewed confirmed this.</p> <p>The in-service training programme includes all mandatory education required. Staff records sampled confirmed education requirements have been met. The organisation requires a broad range of competencies to be completed this includes but is not limited to medication; restraint (including challenging behaviour); first aid; mental health; abuse and neglect. The staff training plan is developed annually and incorporates information gathered from the previous year's quality data. The training plan from 2018 was sampled. Annual practicing certificates for the RN's were sighted. Both the NM and the CM have completed the interRAI training. Caregivers are working toward their level three national qualifications.</p> <p>Staff performance is monitored. This includes annual performance appraisals. Staff records sampled included recruitment, orientation, training, competencies and appraisal records. In interview staff confirmed completion of orientation and attendance at required training. The residents, families and general practitioner (GP) interviewed all reported satisfaction with the knowledge and skills of staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented policy that defines staffing levels. This meets the requirements outlined in the organisation's contracts with the local district health board. There is a registered nurse (RN) on morning shift Monday to Friday. The 24 hours on call RN cover is provided by the CM and the NM. If further RN cover is needed the RN from the other home is available to cover.</p> <p>Rosters sampled evidenced that there are two caregivers on duty in the morning shift; two caregivers on afternoon shift and one caregiver on night shift. Each shift has a caregiver with a current first aid certificate. All sick and annual leave is covered using existing staff, staff from the other facility or on rare occasions by an agency. There are sufficient numbers of kitchen, housekeeping and activities staff. Observations during the audit confirmed that residents' needs were met in a timely manner. Family/whanau and GP interviewed confirmed that staff were available to meet their needs as required.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely</p>	FA	<p>All residents have a hard copy file. All resident records are integrated with allied health providers documenting their entries in a separate location in the integrated folder. Clinical records are documented daily, with additional entries as required and from the registered nurse. All records</p>

identifiable, accurately recorded, current, confidential, and accessible when required.		sampled were signed and designated. A paper register of resident admissions and discharges is maintained. New information and updates are entered within 24 hours. InterRAI records are maintained up to date. Resident files are held in a locked office accessible by staff at any time. Old records are retained for 10 years and held in a secure archive cupboard. Access by persons other than staff is controlled through written application from the resident or EPOA and approved by the NM.
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	There are policies and procedures for entry into the service. A pre-admission form is used to record prospective residents' details. A handbook is made available to families on admission and contains all the information about Greenwood Residential Care. The NM speaks with the resident and or family/whanau to determine the residents care and support needs and suitability and checks with Needs Assessment Service Coordination (NASC) regarding eligibility for funding. Pamphlets that include the Code of Health and Disability Consumer Rights are routinely given to residents on admission.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a documented process for the management of transfers and discharges. A standard transfer notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	<p>The medication charts sampled were signed and dated. There was evidence that GPs undertake medication reviews every three months or earlier if indicated. Medication charts include any drug allergies and a photo of the resident. All medicines and medication charts are stored safely and securely. The facility uses pre-packed medicine system by the pharmacy. A pestle and mortar are used for crushing suitable medicines when required.</p> <p>Pre-packed sachets when delivered from the pharmacy are checked by the CM or NM on duty; evidence of this was sighted. The controlled drug register is current and correct with evidence of weekly and six-monthly stock-takes. There is a process in place for returning expired or unwanted medications.</p> <p>Each staff member administering medicines has completed an annual medication competency. Staff observed during a medication round demonstrated knowledge and understanding of their roles and responsibilities of medicine management.</p>

		There were no residents self-administering their medicines at the time of the audit. The facility had systems and processes in place for self-administration should this be required.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals are prepared on site and served in the dining room; or taken by tray to the residents' room if the resident is unable to attend the dining room. There were enough staff in the dining room during meal time to ensure residents received assistance as required with meals.</p> <p>On admission to the facility the dietary requirements, likes, dislikes and allergies of all residents are recorded, these details are available in the kitchen. The cook was aware of these dietary requirements and updated with any changes. Dietary requirements are accommodated in the daily food plan and alternatives are available to residents when required. There is a system in place for managing food requirements, modified nutritional requirements and special diets. There was evidence the menu had been reviewed by a dietitian.</p> <p>Staff in the kitchen and dining area were observed following handwashing procedures and wearing hair protection. The cook stated all staff are aware of and abide by this requirement. The kitchen and pantry are clean, tidy and well stocked. Food procurement is managed by the cook. There was evidence that regular cleaning is undertaken. Labels and expiry dates are on all containers and decanted foods, and expired foods are discarded. Food temperatures, fridge and freezer temperatures are recorded. There was a current Food Control Plan in place. The kitchen staff have current food handling certificates.</p> <p>Resident's files demonstrated monthly monitoring of weight and supplements are offered to residents when necessary.</p> <p>Residents and family/ whānau interviewed generally expressed satisfaction with meals. Where suggestions for improvement had been made there is evidence that these suggestions were being implemented.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>Entry may be declined where the resident has no funding or the NM and the CM assess that the residents needs cannot be met by from current staff or resources. There is a form available for use when a resident has been declined entry, this was sighted. Management said they would refer consumers and or their family back to the NASC team when service is declined or provide the family with alternative suggestions.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Initial assessment tools are used to assess the residents' needs, support requirements and preferences on admission. InterRAI assessments are completed in a timely manner. The assessed needs, outcomes and goals identified through the assessment process are documented to serve as a basis for service delivery. Assessments are conducted in a safe and appropriate setting as confirmed by the interviewed GPs. Assessment outcomes are communicated to the residents and/or their family/whanau and referrers and relevant service providers.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans sampled were resident focussed, integrated and provide continuity of service delivery. Short term support needs and wound care plans are completed as required. Residents, their family/whanau and relevant key workers are involved in the care planning process. The care plans sampled described the required support to achieve the desired outcomes identified by the ongoing assessment process. Service integration was sighted in the sampled residents' files.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The documented interventions in short term support needs care plans and resident lifestyle care plans are sufficient to address the residents' assessed needs and desired goals/outcomes. Interventions are updated when required and interRAI triggered outcomes are addressed. Specialist advice is sought from other service providers and specialist services when required. Referral documents to other services and organisations involved in residents' support were sighted in the sampled files. Interviewed families, residents and staff reported that they were satisfied with the services provided. Interviewed staff reported that there are adequate resources to meet safe resident care. Adequate medical/clinical resources were sighted and were appropriate to the size of the facility.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Activities are planned by the activity's coordinator in consultation with the CM and NM. A monthly planner is distributed to all residents and posted on the notice boards that are accessible to residents. A resident preference/choice of activities form is completed on admission. The activities provided take into consideration residents' interests and ability. Residents and their family/whanau are consulted in the activity's assessment and planning process. There is a wide range of activities offered: including bingo; quiz; music sessions; walking groups; scrabble, happy hour and house. There is community involvement with external entertainers invited, church and music groups. Daily activities attendance checklist is completed, and documentation was sighted. Activities range from group to one on one and cater to those under 65 years of age. Evaluation of the individual activity plans are completed six-monthly.</p>

		<p>Van outings are conducted once a week to areas of interest. Monthly residents' meetings are conducted, and outcomes are implemented and communicated to family/whanau and residents. Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' life style care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes. Family/whanau and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term support needs care plans are developed when needed and signed and closed out when the short-term problem has resolved.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are referred to other health and disability service providers when required. Referral documents were sighted in the sampled files. The GPs are involved in the referral process in consultation with the resident and/or their family where appropriate. Informed consent, general consent forms and referral documentation were sighted in records sampled. Residents and/or their family are given the choice and advised of their options to access other health and disability services where indicated.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes are in place for the management of waste and hazardous substances including specific labelling requirements. Material safety data sheets are available and accessible for staff. Education on chemical safety was provided as part of the staff in-service education programme. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>Observations provided evidence that hazardous substances are correctly labelled and securely stored. The containers appropriate for the contents including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>A current building warrant of fitness was displayed. The sampling of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme in place</p>

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		<p>that ensures buildings; plant and equipment are maintained to an adequate standard. Documentation reviewed, the nurse manager interviewed, and observation confirmed this. The testing and tagging of equipment and calibration of bio medical equipment is current.</p> <p>There is a covered external area available that is safely maintained and is appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use any equipment.</p> <p>Residents confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Bedrooms have either shared toilet ensuites or full shower ensuite. There are three accessible communal bathrooms, toilets and hand basins for residents. Toilets and showers are of an appropriate design with reversible locks which indicate if they are vacant or occupied. All bathrooms have handrails, call bells, and raised toilet seats where required. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are maintained at a safe temperature.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are 21 single and 3 double bedrooms. Double bedrooms are usually only used by couples. Adequate privacy is available if bedrooms are shared. All rooms were personalised to varying degrees. Bedrooms are large enough to provide personal space for residents and allow staff and equipment to move around safely.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	FA	<p>Adequate access is provided to the lounges and dining area. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being conducted in one of these areas and they do not want to participate in them.</p>

accessible areas to meet their relaxation, activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry policy and procedures were available. There were policies and procedures for the safe storage and use of chemicals.</p> <p>All linen is washed on site and there is adequate dirty / clean flow in the laundry. Care staff are responsible for laundry and they described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner described cleaning processes.</p> <p>Observations provided evidence that: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals were labelled and stored safely within these areas; chemical safety data sheets or equivalent were available; appropriate facilities exist for the disposal of soiled water/waste (such as the sluice room), convenient hand washing facilities are available, and hygiene standards are maintained in storage areas.</p> <p>Residents and family interviewed stated they were satisfied with the cleaning and laundry service and this finding was confirmed during review of the satisfaction survey questionnaires.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification are available. Policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors are available.</p> <p>A New Zealand Fire Service letter approving the fire evacuation scheme was sighted. Trial evacuations are held every 6 months.</p> <p>Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.</p> <p>Information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non-drinkable supply), blankets and cell phones. The provider also has emergency</p>

		<p>generators.</p> <p>There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident groups and setting. Call bells are accessible/within reach and were available in resident bed rooms and communal areas. Residents confirmed they have a call bell system in place which is accessible, and staff respond to it in a timely manner.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility is maintained at an appropriate temperature. All resident rooms have adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. Environmental temperatures are monitored and recorded monthly.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>There is evidence that the environment is managed to minimise the risk of infection to consumers, service providers and visitors. The infection prevention and control manual provide information to staff that is appropriate to the size and scope of the facility. The infection control coordinator is the NM and is accountable for infection control within the facility. This is evident in the job description sighted.</p> <p>There is evidence that infection control is discussed during staff hand-overs and as an agenda item in staff meetings. Infection control reports are made available to staff and forwarded to the facility owner. An infection control programme is in place and reviewed annually. There is input from GPs and copies of microbiology reports are contained in resident's notes. Infections and antibiotic use are monitored, graphed and benchmarked. There are policy and procedures in place in the event of an outbreak. Residents have their own hand-basin in their room and there are stations for hand sanitisers within the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control</p>	FA	<p>There was evidence that the ICC has access to adequate resources to implement the infection control programme. The ICC reported that there is adequate human, physical, and information resources to implement the programme. There is an infection prevention and control manual, hand sanitisers throughout the facility, gloves for staff use; and hand-basins with pump-soap in each resident's room.</p>

programme and meet the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	Staff have access to an infection prevention and control manual developed externally, which contains policies and procedures for prevention and control of infection within the facility. The contents of the manual are updated regularly to reflect current accepted good practice and guidelines.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	There is evidence that the ICC and staff have attended in-service training sessions provided by external service providers with expertise in infection control within the previous year. The training content meets best practice and guidelines. The ICC maintains a record of attendees. Staff also have access to an infection control expert advisor. External contact resources included: GP practice, laboratories and local district health boards. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until the infection is contained. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	There is a policy in place for infection prevention and control which is appropriate for the size and complexity of this organisation. The ICC monitors all infections, causative organisms, and antibiotic use. The trends and findings are made available in the staff meeting minutes, staff handovers and the risk management monthly report. An infection control walk around audit occurs monthly. All staff and management it was confirmed there has been no outbreak within the facility within the last year.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of</p>	FA	There is a documented restraint policy and procedure. The definition of restraint and enabler is congruent with the definitions in NZS 8134. De-escalation and behaviour management is actively practiced. There were no restraints or enablers in use on day of audit. There has been one incidence

restraint is actively minimised.		<p>of restraint since the last audit.</p> <p>The NM is the restraint coordinator and actively promotes a restraint free environment. There was evidence in staff interviews and training records that restraint minimisation and safe practice (RMSP), voluntary enabler usage and prevention and/or de-escalation education and training has been provided.</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>The approval process for restraint use is clearly defined in the documented policy. The policy includes procedures for assessment, planning, consent, approval, monitoring records and review. The NM is the restraint coordinator and is responsible for communicating with the family and the GP prior to approval of the restraint or enabler. The restraint care plan is documented in the resident's care plan. Review of the one incident of restraint confirmed compliance with the approval process.</p> <p>The education plan and staff training records indicate that on-going education in restraint minimisation, behaviour management and enabler use is provided.</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>The documented restraint assessment process included identification of restraint related risks; underlying causes for behaviour that requires restraint; existing advanced directives; past history of restraint use; history of abuse and or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. This was evident in the restraint record sighted.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>One restraint event was recorded in the restraint register. The resident is no longer at the facility. Review of the archived record indicated that the process had been implemented in accord with the documented policy. A restraint management plan was in place. Strategies were implemented prior to use of restraint to prevent the resident from incurring injury. The consent for restraint use was completed and signed by the GP, the restraint coordinator and the family member with EPOA. Monitoring and care requirements were clearly defined, and records sighted indicated that detailed reports were maintained in the resident's notes.</p>
Standard 2.2.4: Evaluation	PA Low	<p>The documented policy requires evaluation of each episode of restraint. There was no evidence of</p>

Services evaluate all episodes of restraint.		formal evaluation of the one episode that had occurred.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	PA Low	The documented restraint process requires quality review every 6 months. There was no evidence that this had occurred.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Moderate	<p>Review of six records of resident accidents and incidents found that documentation was detailed, there were no serious injuries and families were notified. The facility policy for assessment of a resident following an unwitnessed fall includes a requirement for neurological observations to be done. However, four of the six had had an unwitnessed fall but there was no evidence that neurological observations were part of the post fall assessment. Staff interview indicated that they were unaware of this requirement. In one case where the</p>	<p>Neurological observations are not done when a resident has an unwitnessed fall.</p> <p>Residents who complain of dizziness leading to a fall do not have their</p>	<p>Provide evidence of training for staff in the requirement to undertake neurological assessment when a resident has an unwitnessed fall and review medications where a</p>

		resident complained of dizziness leading to the fall, there was no evidence of a medication review.	medications reviewed.	<p>resident complains of dizziness leading to a fall.</p> <p>Include a place in the accident report form to report these items.</p> <p>90 days</p>
<p>Criterion 2.2.4.1</p> <p>Each episode of restraint is evaluated in collaboration with the consumer and shall consider:</p> <p>(a) Future options to avoid the use of restraint;</p> <p>(b) Whether the consumer's service delivery plan (or crisis plan) was followed;</p> <p>(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);</p> <p>(d) Whether the desired outcome was achieved;</p> <p>(e) Whether the restraint was the least restrictive option to achieve the desired outcome;</p> <p>(f) The duration of the restraint episode and whether this was for the least amount of time required;</p> <p>(g) The impact the restraint had on the consumer;</p> <p>(h) Whether appropriate advocacy/support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;</p> <p>(j) Whether the service's policies and procedures were followed;</p> <p>(k) Any suggested changes or additions required to the restraint education for service providers.</p>	PA Low	There was no evidence of formal evaluation of the one episode of restraint that had occurred.	Review and evaluation of each individual episode of restraint use has not been done.	<p>Provide evidence of review and evaluation of the one restraint episode recorded in the restraint register.</p> <p>180 days</p>

<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	PA Low	The documented restraint process requires quality review every 6 months. There was no evidence that this had occurred.	Review and evaluation of restraint processes has not been undertaken.	<p>Provide evidence of review of restraint processes, as required by the organisational documented policy.</p> <p>180 days</p>

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.