

# Lexham Gardens Limited - Lexham Gardens Rest Home and Hospital

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## Introduction

This report records the results of a Provisional 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:

<b>Legal entity:</b>	Lexham Gardens Limited
<b>Premises audited:</b>	Lexham Gardens Rest Home and Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 24 September 2020    End date: 25 September 2020
<b>Proposed changes to current services (if any):</b>	Change of ownership. Add medical to the geriatric hospital service.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	46



# Executive summary of the audit

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## 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.

## General overview of the audit

Lexham Gardens Rest Home provides rest home and hospital level care for up to 50 residents. The facility is operated by Glenlaurel Care Limited. The service is managed by an owner/facility manager and a clinical manager. Residents and families spoke positively about the care provided.

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

The audit also established how well prepared the prospective provider is to provide a health and disability service. One of the two directors for Lexham Gardens Limited was interviewed during this audit. The prospective provider understands the Health and Disability Standards and the Age Residential Related Care Agreement.

The organisation meets the criteria for the addition of medical to be added to the existing service.

There are no improvements required from this audit.

## **Consumer rights**

The facility manager is responsible for the management of complaints and a complaints register is current. There has been an investigation by the District Health Board since the previous audit.

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 rights 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 and when required. Staff provide residents and families with the information they need to make an informed choice and to give consent.

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

The service has linkages with a range of specialist healthcare care providers to support best practice and meet resident's individual needs.

## Organisational management

Glenlaurel Care Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at Lexham Gardens Rest Home and include a mission statement, philosophy scope, objectives, values, and goals. Systems are in place for monitoring the service, including regular reporting by the clinical manager to the owner/facility manager.

The service is managed by an experienced facility manager who also is one of the owners. The facility manager is supported by a clinical manager who has oversight of clinical services in the facility.

Quality and risk management systems are followed. There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff, registered nurse and resident meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks.

Policies and procedures on human resources management are in place and processes are followed. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are always rostered on duty. The clinical manager and facility manager are on call after hours.

Resident information is uniquely identifiable, accurately recorded and securely stored. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

## **Continuum of service delivery**

The entry requirements for rest home and hospital level of care are clearly documented. Residents and families receive accurate information on admission to the service. If entry to the service is declined, a record is maintained and the potential resident and/or their family/whānau referred to a more appropriate service.

The processes for assessment, planning, provision of care, evaluation, review, and exit from the service are provided within time frames that safely meet the needs of the resident and contractual requirements. The service has implemented the required electronic assessment tool (interRAI). The care plans described the required support and/or intervention to achieve the desired outcomes. The evaluation record showed the progress the resident is making towards meeting their goals. Where progress is different from expected, the service responds by initiating changes to the care plan or with the use of short term care plans. The service is coordinated in a manner that promotes continuity in service delivery and a team approach to care delivery.

Referral to other health or disability service providers is facilitated by the general practitioner or registered nurse. There is an appropriate process and risk assessments to facilitate any discharge or transfers to other providers.

The service provides a planned activities programme to develop and maintain skills and interests that are meaningful to the residents.

There are processes in place for safe medicine administration. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage. There are some residents who self-administer their medications.

The families and residents report satisfaction with the meal services. The menu is reviewed by a dietitian. The service has a food control plan displayed which is current.

## **Safe and appropriate environment**

A current building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

Single accommodation is provided with a mix of full ensembles and rooms with a wash hand basin and toilet. Adequate numbers of additional bathrooms and toilets are available. There are several lounges, dining areas and alcoves. External areas for sitting and shading are provided.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. Laundry is contracted offsite and both cleaning and laundry is evaluated for effectiveness.

Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held six monthly. Residents reported timely responses to call bells.

## **Restraint minimisation and safe practice**

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Restraints were in use. Documentation includes assessment, approval, monitoring and review processes. Staff interviewed demonstrated a sound knowledge and understanding of restraint minimisation and safe practice.

## **Infection prevention and control**

There are appropriate systems in place for infection prevention and control. The infection control coordinator attends and provides regular staff education related to infection prevention and control. The documented policies and procedures for the prevention and control of infections are regularly reviewed. The infection control programme is reviewed annually.

Surveillance for infections is conducted monthly. Results of surveillance are collected, collated and analysed to identify any trends and prevent or minimise further infections.

## 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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Lexham Gardens Rest Home has processes, policies and procedures to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed had a good understanding of 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 provided to staff during the orientation process and was also included in the ongoing training programme evidenced in training records. Staff were observed calling residents by their preferred name.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The RNs and the care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical records reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for outings, photographs and sharing information.</p>

		Advance care planning is being implemented and documentation of enduring power of attorney (EPOA) requirements and processes are better understood by RNs and are evident in resident records as applicable. Staff were observed to gain consent for day to day care on an ongoing basis. Informed consent forms are signed and dated in the individual resident's records reviewed for administration of the annual influenza vaccination.
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 about the Nationwide Advocacy Service. Posters related to the Advocacy Service are also displayed in the facility and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service and how to access this. They were also informed of their right to have support persons.  Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed at the time of audit.
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 and entertainment.  The facility has normally unrestricted visiting hours and encourages visits from resident's family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealing with the staff. The experience during the pandemic has focused on arranged visits mostly but this has worked effectively for family interviewed.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The facility manager (FM) is responsible for the management of complaints. The complaints and compliments forms and associated documents meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (The Code). Information on

		<p>the complaint process is provided to residents and families on admission and was available throughout the facility. Residents and families knew how to make a complaint and to provide compliments.</p> <p>The complaints register evidenced three verbal complaints have been received since the previous audit and that actions taken through to an agreed resolution were documented and processes completed within the timeframes required. Action plans showed any required actions or improvements that have been made where possible. Complaints are graphed and displayed in the staff room for staff to view. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>One complaint has been received by the MoH and investigated by the DHB since the previous audit. The complaint related to the care of a resident, the food service and outings into the community. Documentation reviewed evidenced the FM received an email from the DHB dated 27 February 2020 requesting a response to the complaint. A response to the allegations with supporting documentation was provided to the DHB on the 2 March 2020. A further email dated 25 May 2020 from the DHB determined the complaint was not substantiated and the matter is now closed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	<p>FA</p>	<p>The prospective provider demonstrated knowledge and understanding of consumer rights.</p> <p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy service as part of the admission information provided and discussed with staff. The code is displayed near the reception and main lounge areas, together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a</p>	<p>FA</p>	<p>Residents and families of Lexham Gardens Rest Home confirmed they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices are provided.</p>

<p>manner that has regard for their dignity, privacy, and independence.</p>		<p>Staff interviewed understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and in discussion with families. All residents have their own room except for a married couple who share a room. The facility manager is the privacy officer. Training is accessible online and has been completed.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings with the activities programme provided. Each care plan and activities plan included documentation related to the resident's abilities and strategies to maximise resident independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified in the assessment process and included into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff and is then provided on an annual basis, as confirmed by staff and in training records reviewed.</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>	<p>FA</p>	<p>There are no residents at Lexham Gardens Rest Home currently who identify as Maori. Interviews with staff identified that they are able to provide cultural values and beliefs when needed. Cultural safety policies are available to staff to provide culturally safe care. The principles of the Treaty of Waitangi are incorporated into the day to day practice, as is the importance of whanau to Maori residents. There is a policy on Maori Health planning and a Tikanga Best Practice guideline is available to guide staff.</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</p>	<p>FA</p>	<p>Residents of Lexham Gardens Rest Home 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 all care plans</p>

<p>respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supported that individual needs are being effectively met.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe at this facility. The general practitioner interviewed expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment agreement. Ongoing education is also provided on an annual basis, which was confirmed in the staff training records reviewed. Staff are guided by policies and procedures and when interviewed demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Lexham Gardens Rest Home encourages and promotes good practice through evidenced policies and procedures. Input is sourced from a contracted external quality person as needed. Medical and allied health professionals are sought on a referral basis or are contracted to the service for example the hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care nurse, the contracted dietitian and other health professionals.</p> <p>Staff reported they receive management support for education. Education is provided internally and on-line learning with a contracted education provider is available. The registered nurses are invited to participate in education provided by the district health board.</p> <p>Other examples of good practice observed at Lexham Gardens Rest Home included continuity of clinical expertise. There is a commitment</p>

		<p>to ensuring all staff maintain their competencies regarding meeting clinical expectations. The clinical manager and the senior registered nurses assess all staff competencies with input of the facility manager. Staff who are involved with medication administration complete annual competencies.</p> <p>There are a number of ongoing initiatives aimed at reducing the number of falls, minimising the use of restraint/enablers and always improving the management of wounds demonstrating a commitment to good practice and care delivery at Lexham Gardens Rest Home.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's health 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 resident's records reviewed. There was evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are able to be accessed via the district health board and when need by family members and/or staff for whom English is not their first language.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Glenlaurel Care Limited is responsible for the services provided. A business plan 2020-2021 was reviewed and includes a mission statement, philosophy, scope, objectives, values, and goals. Annual and longer-term objectives and the associated operational plans were sighted. The mission statement and philosophy of the organisation is also displayed at the entrance to the facility. The facility manager is a director of the service but does not own the building. The FM demonstrated a sound knowledge on all aspects of the service provided including the monitoring of performance.</p> <p>The FM has been in their current position for five years and prior to this appointment has managed other aged care facilities. The management of clinical services is the responsibility of the clinical</p>

		<p>manager (CM) who has been in the position for five years and prior to this role was an RN on the floor. There was evidence in the facility manager's and clinical manager's files of appropriate ongoing education. The CM has a current practising certificate and the facility manager is the trained assessor for Careerforce.</p> <p>The prospective provider, Lexham Gardens Limited consists of an executive chairman and a managing director. Both have extensive governance and management backgrounds in the aged care sector.</p> <p>A comprehensive transition plan reviewed and interview of the prospective provider and the current owner evidenced the current owner is committed to providing a comprehensive handover during the transition period until the 10 November 2020, when it is envisaged the prospective provider will take ownership.</p> <p>A new facility manager is to start employment on the 27 October 2020. The new manager is an RN with extensive experience in managing aged care facilities and in operational positions within other aged care organisations. All current staff will be offered ongoing employment. The prospective provider will provide governance and management support to the Lexham Gardens management team. The prospective provider has notified the District Health Board of the change of ownership.</p> <p>The prospective provider stated a mission statement and values statement will be developed with input from residents, families and staff. In the interim the current vision, mission and values will be referred to.</p> <p>Occupancy on the first day of the audit consisted of 46 residents, 34 assessed as hospital level including one resident under the chronic health contract. Twelve residents were assessed as rest home level.</p> <p>The service provider has funding contracts with the district health board (DHB) to provide aged related residential care (rest home and hospital) and long-term support chronic health conditions.</p> <p>All rooms have been approved as dual purpose apart from two that are for rest home level only.</p>
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<p><b>Standard 1.2.2: Service Management</b></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>	<p>FA</p>	<p>When the facility manager is absent the clinical manager covers all aspects of the service. During absence of the clinical manager a senior registered nurse is available to cover for the clinical manager. A senior registered nurse is supported by the registered nurses on shift. The registered nurse cover is provided 24 hours a day seven days a week. Staff interviewed reported that the current arrangements work well.</p> <p>The prospective provider understood the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality improvement and risk management plan guide the quality programme that reflects the principles of continuous quality improvement.</p> <p>Quality, health and safety, restraint and infection prevention and control combined staff meetings and separate RN meetings are held monthly. Resident meetings include topics of interest. Meeting minutes including quality data are available in the nurses' station for staff to read. Meeting minutes evidenced reporting of completed internal audits, comprehensive quality data, including clinical indicators which are graphed. The FM is experienced in quality and risk management processes and is responsible for ensuring the organisation's quality and risk management systems are maintained.</p> <p>Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed. There was documented evidence quality improvement data is being collected, collated, comprehensively analysed and reported. Quality improvement data reviewed included adverse event forms, internal audits, meeting minutes, satisfaction surveys, infection rates and health and safety. Corrective action plans are being developed, implemented, monitored and signed off as being completed.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant</p>



		<p>to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed they are advised of updated policies and that they provide appropriate guidance for service delivery. The service meets the criteria for medical to be added to the certification of the service.</p> <p>Actual and potential risks are identified associated with human resource management, legislative compliance, contractual and clinical risk. The hazard register identifies hazards and evidenced the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The FM is the health and safety coordinator and is responsible for hazards. The FM demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.</p> <p>The prospective provider advised the current policies and procedures will remain the same with the change of ownership. The current quality and risk management plan will remain. The prospective provider reported they plan to review the plan within three months of ownership.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form including neurological observation and falls risk assessments following accidents/incidents as appropriate. All clinical incident/accident forms are collated by the CM. The FM stated they are responsible for all non-clinical completed forms. A copy is kept in the residents' file. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse</p>

		<p>event or change in their relative's condition. The satisfaction surveys confirmed this.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM advised there has been one essential notification made to the Ministry of Health since the previous audit.</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective provider is aware of all current health and safety legislative requirements and the need to comply with these.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting. The service meets the criteria for medical to be added to the certification of the service.</p> <p>The education programme is the responsibility of the FM and is a strength of the service. In-service education is provided for staff using several ways including at least monthly sessions, on-line learning. Toolbox talks at handover, specific topics relating to resident's health status and staff meetings. The local DHB also provides an education programme for both RNs and health care assistants and staff have also attended other external education. Individual records of education are held on staff files and electronically. Competencies were current including but not limited to medicines, restraint, manual handling, fire safety and personal cares. Attendance records are maintained. Education sessions are evaluated by the FM and any corrective actions developed and implemented. Five of the seven RNs are interRAI trained and have current competencies including the CM.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. The FM is the assessor for the facility.</p>

		<p>An orientation/induction programme is in place and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to a month to complete and staff performance is reviewed at 12 weeks and annually thereafter. Orientation for staff covers all essential components of the service provided.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. The FM and CM reported they review the rosters continuously and consider dependency levels of residents and the physical environment. There are two RNs and seven HCAs rostered on the morning shift, plus the CM who works full time Monday to Friday inclusive. Two RNs and four HCAs are rostered on the afternoon shift. One RN and two care givers are on the night shift. There are dedicated cleaners and HCAs and cleaners are responsible for managing the laundry. The owner of the building is responsible for all maintenance and the FM takes care of the gardens. A diversional therapist works full time. The FM and CM are on-call after hours. The FM for non-clinical issues and the CM for clinical issues.</p> <p>Care staff interviewed reported there is adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided. The FM stated there is no casual pool at present, however, any shortages are covered by increasing staff hours if need be. Of the RNs employed, one RN has a years experience in working in the aged care sector.</p>

		<p>The other RNs have more than two years experience. The service meets the criteria for medical to be added to the certification of the service.</p> <p>The prospective provider intends to maintain the current staffing levels and skill mix. The prospective provider understood the required skill mix to ensure hospital and rest home residents needs are met.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) Number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical notes were current and integrated with the GP and allied health service provider records. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily accessible. Residents' records are held for the required period before being destroyed. No persona or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The FM manages entry to the service. An enquiry form records all enquires and if the potential resident has an appropriate assessment for rest home or hospital level of care. The resident information handbook contains accurate information about the service. All residents' files contain an appropriate needs assessment. The service updates any vacancy on the Eldernet website each weekday. The facility maintains good occupancy.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>When admission has been required to the acute care hospital, the service utilised the DHB's transfer form/envelope. The referral process documented any risks associated with each resident's transition, exit, discharge, or transfer. This included expressed concerns of the resident and family/whānau and a copy of any</p>

		<p>advance directives. Along with the transfer form/envelope, the RN reported that the service also provides a copy of any other relevant information.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The observed medication procedures are implemented to meet legislative and best practice requirements and in line with the Medicine Care Guides for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of the 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. The processes for controlled drug management meet requirements. There are no standing orders.</p> <p>Records for temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>The medications are individually prescribed for each resident and delivered to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. There is no bulk supply of medications.</p> <p>The medications are delivered by the pharmacy in a pre-packed administration system. These medication packs and the signing sheets are checked for accuracy by the RN. Three monthly medication reviews are recorded in the residents file and on the medication chart. Good prescribing practices noted include the prescriber's signature and date being recorded on the commencement and discontinuation of medicines and all requirements for pro rata (PRN) medicines were met.</p> <p>There were no residents who were self-medicating medications at the time of the audit. Appropriate processes were in place to ensure this can be managed safely.</p> <p>Medication errors are reported to the RN or the clinical manager and</p>

		recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors and compliance with this process was verified.
<p>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>There is a four-week rotational menu that has summer and winter variations. This menu has been reviewed by a dietitian in the last on the 20 July 2020. Residents with specific nutritional needs have these met. The kitchen staff receive a copy of the nutritional requirements for each resident. Residents are routinely weighed monthly or more frequently if there is a clinical need. Nutritional supplements are available to residents assessed as requiring these. The RN and residents/families report there have been no issues with unintentional weight loss.</p> <p>The kitchen services are based on the food safety principles. There are appropriate processes in place for the purchasing, preparation and disposal of food that complies with current legislation and guidelines. The kitchen staff have food safety training. The food safety control plan displayed expires March 2021. Residents and families verified that they are pleased with the food service.</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>The facility manager reported if the service is to decline entry to a potential resident, this is recorded. When entry is declined, the referred, prospective resident and family are informed of the reason why.</p> <p>An admission agreement is developed through an aged care association that is then personalised to the service. The agreement has clauses on the change in level of care process when the service can no longer meet the needs of the resident. As the service provides rest home and hospital level of care, should the needs of the resident increase beyond this level, the resident is reassessed and referred to a service that is better able to meet the higher level of need. The service has had occasions where residents have been required to transfer to a service providing dementia or psychogeriatric level of</p>

		care.
<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>The assessments and reassessments are conducted using the electronic interRAI assessment process. All files have an initial interRAI assessment. The service also uses their own paper based assessments for additional needs that are identified through the assessment process; this includes behaviour assessments, nutrition, falls, wound assessment, pressure injury risk. Where there is a greater need or risk, reassessments occur more frequently such as monthly falls risk, risk of malnutrition assessments or pain assessments, that are conducted at each PRN (pro re nata – 'as required') medication administration. There is a summary of the assessed needs of the resident and these are then documented on the care plan. The files record and residents/families report that the care provided meets the resident's needs.</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 are based on the outcomes from the assessments and the identified needs of the resident. The care plan format includes the resident's specific needs, goals/aims and staff interventions required to address those needs. Those reviewed evidenced family consultation and input into their planning. There are specific care plans developed for falls management, pressure injury prevention and minimising reoccurrence of challenging behaviours. Residents and families reported satisfaction with the care and with specific management of their relative's medical conditions.</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 provision of services and interventions are consistent with meeting the needs of the residents. Resident's records are individualised and personalised to meet the assessed needs of the resident. The care was observed to be flexible and focused on promoting quality of life for the residents. All the residents and families reported satisfaction with the care and service delivery.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The residents are included in meaningful activities at the care facility. There is an activities coordinator Monday to Friday and staff assist with the planned and diversional activities over the weekend. Staff reported that they gauge the response of residents during activities and modified the programme related to the response and interests. The activities are modified according to the capability and cognitive abilities of the residents.</p> <p>The activities programme covers physical, social, recreational and emotional needs of the residents. Residents were observed to be participating in meaningful activities both inside and out in the grounds of the service during the audit. The residents and families reported overall satisfaction with the level and variety of activities provided. Residents were observed to be going offsite with family/friends.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluations are conducted at least six monthly and recorded on the care plan. The service uses the built in evaluation scores when the service reassesses the resident using the interRAI assessment as part of the evaluation process. Care evaluations are conducted for all the residents' needs and recorded how each of the resident's goals have been met over the past six months.</p> <p>When there are changes in the resident's needs, the service uses a short term care plan to capture these changes. The short term care plans identify the need, interventions and evaluation of the interventions. If the issue then becomes a long term need, these are then recorded and updated on the long term care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Each of the residents is able to maintain their own GP if available, with a facility GP available. The RN or GP arranges for any referral to specialist medical services when it was necessary. The resident's files have appropriate referrals to other health and diagnostic services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous</p>	<p>FA</p>	<p>Policies and procedures specify labelling requirements in line with</p>



<p><b>Substances</b></p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current.</p> <p>Protective clothing and equipment were sighted in the sluice room and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed that expires 4 June 2021. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Passageways are wide and residents confirmed they can move freely around the facility and that the accommodation meets their needs.</p> <p>There is a proactive and reactive maintenance programme and the buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by the owner of the building and was observed to be of a high standard. The testing and tagging of electrical equipment and calibration of bio-medical equipment is current. Hot water temperatures at resident outlets are maintained within the recommended range.</p> <p>There are external areas available that are maintained to a high standard and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. The gardens are well maintained including a large courtyard in the centre of the facility which is inviting for residents and their family to frequent. Hanging baskets have an array of bright coloured flowers outside the residents' bedrooms that face the courtyard.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p> <p>The prospective provider stated there are currently no plans for any environmental changes to the facility.</p>

<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></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>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Twenty-two rooms have their own ensuite and the rest have a toilet and wash hand basin. There are additional toilets and showers in close proximity to the residents' rooms. In addition, there are two toilets one of which is a disability toilet near the main lounge/activities room. All bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. Separate bathrooms for staff and visitors are available.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photographs and other personal items on display. All bedrooms are large enough for residents and staff and equipment to manoeuvre within.</p> <p>There is adequate room in the facility to store mobility aids such as mobility scooters, wheelchairs and walkers.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to frequent. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy. There is one smaller lounge available for this purpose. The furniture in the lounges and dining room is appropriate to the setting and residents' needs.</p> <p>There is adequate space to accommodate wheelchairs in the dining room and large lounge if required.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p> <p>Consumers are provided with safe and hygienic cleaning and</p>	FA	<p>Laundry is contracted out to an external company. Residents' personal clothing is washed and dried at the facility in the laundry provided. The laundry is spacious and both care and cleaning staff</p>

<p>laundry services appropriate to the setting in which the service is being provided.</p>		<p>are responsible for the personal clothing. Care staff and cleaners demonstrated a sound knowledge of the laundry processes, dirty and clean flow and handling of any soiled linen. Residents and families interviewed reported the personal clothes are managed effectively and returned in a timely manner. There are separate named baskets for each individual resident. Once linen is folded and placed in the baskets these are given out by staff and put away in the residents' bedrooms.</p> <p>The facility is cleaned to a high standard. The dedicated cleaners have received appropriate training. The cleaners have completed on-learn learning plus training from the chemical company representative who visits monthly. Chemical are stored in a lockable cupboard and were in appropriately labelled refillable containers. The cleaning trolley is stored in a locked sluice room when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 27 March 2000. A fire evacuation drill takes place six monthly with a copy sent to the New Zealand Fire Service. The last trial was held on the 24 July 2020. The orientation programme includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Policies and procedures and guidelines for all emergency planning, preparation and response are displayed and flip charts are displayed throughout the facility to guide staff. Disaster and civil defence planning guides direct the facility in their preparedness for disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>Adequate supplies for use in the event of a civil defence emergency including food, water, blankets, torches both hand and head variety, mobile phones and a gas barbecue were sighted and meet the requirements for the number of residents able to be accommodated at the facility. Water storage meets the requirements for the emergency water storage recommendations for the Auckland region. There is a generator on site and external emergency lighting that can run off the generator as well as emergency lighting in the facility. These</p>

		<p>resources are regularly tested and recordings were validated. Three large bins which are locked and checked regularly contain all emergency resources for the event of an emergency. These are labelled and all staff interviewed were aware of the locality of the bins outside should they be required.</p> <p>A new call bell system was installed in June 2020. Call bells alert staff to residents requiring assistance. Audits are completed on a regular basis and residents and families reported staff respond in a timely manner. Call bells were observed in all service areas within the facility.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the facility is checked by staff. Surveillance cameras are evident in the communal areas of the facility and signage is available.</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>Heating is provided by under floor heating. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. There is a covered external area for smokers.</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>Lexham Gardens Rest Home provides a managed environment that minimises the risk of infection to residents, visitors and staff through the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed and implemented by the clinical manager and more recently an RN is orientating to the role of infection control nurse (last two months). The role and responsibilities are outlined in the job description sighted. The infection prevention and control programme is reviewed annually.</p> <p>The clinical manager has overseen the infection prevention and control programme for six years. Infection control matters, including</p>

		<p>surveillance results are reported monthly and tabled at the staff /quality meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 24-48 hours not to enter the facility. Covid 19 preparedness made management of the pandemic easier and with additional education staff performed their duties effectively. The infection control manual provides guidance for staff about how long they must stay away from work, whether they required getting tested, if they have been unwell. Staff interviewed understood these related responsibilities and did what was asked of them under the circumstances.</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 programme and meet the needs of the organisation.</p>	FA	<p>The clinical manager is the infection control nurse (ICN) but has been orientating a registered nurse for the last two months. The RN is experienced and committed to this role and stated at interview that she is passionate about infection control practices. The RN is enrolled in the required training at the DHB for the next available course. Well established local networks with the infection control team at the DHB are available and further expert advice from an external advisory group is also accessible. Advice through the GP practice is also available when support/information is needed. Apart from the international/national pandemic there have been no further outbreaks since the previous audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following the facilities policies such as appropriate use of hand-sanitisers, good hand-washing techniques and use of disposable aprons and gloves, as was appropriate for the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

<p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection prevention and control programme annual plan. Interviews, observation and documentation verified staff have received the required education in IPC at orientation and ongoing education sessions. Education is provided by the infection prevention and control nurse and the registered nurses Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred there is evidence the additional staff education has been provided in response. Education was provided to all staff and families, throughout the current pandemic Covid 19 outbreak. Signage is available and is displayed in the clinical areas.</p> <p>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 the warmer weather.</p>
<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover to ensure early interventions occurs.</p> <p>The ICN reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic database. Graphs are produced that identify trends for the current year and comparisons against previous years. Data is displayed in a framed noticeboard in the staff room for staff to review.</p>

		For the size of this facility the infection control rate is recorded as being quite low.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service demonstrated that the use of restraint is actively minimised. There were nine residents using restraint and no residents using an enabler during the audit. Enablers were the least restrictive and used voluntarily at the residents' request. The restraint coordinator is an RN and was unavailable during the audit. The CM demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register is current and updated. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two.</p> <p>The restraint approval group forms part of the staff meetings. Restraint is also an agenda item at the staff meetings. Meeting minutes and staff confirmed this.</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>Restraint approval is authorised by the registered nurse who is the restraint coordinator, the GP and family. It was evident from review of restraint approval forms and residents' records and interviews with staff and CM that there are clear lines of accountability that all restraints have been approved and the overall use of restraints is being monitored and analysed. Evidence of family involvement in the decision making was on record in each case.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were clearly documented and included all requirements of the standard. The RN on any shift undertakes the initial assessment with the restraint coordinator's involvement and input from the resident's family. The CM described the documented process. Families confirmed their involvement. The GP is involved in the final decision on the safety of the use of the restraint. The assessment process using a restraint/enabler questionnaire identified the underlying cause, history of restraint use,</p>

		<p>cultural considerations, alternatives and associated risks involved. The desired outcomes were to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	FA	<p>The use of restraint is actively minimised and the CM described alternatives to restraints including low beds and sensor mats. When restraints are in use, frequent monitoring occurs to ensure the resident is safe. Records of monitoring had the necessary details and were completed correctly. Access to advocacy is provided and all processes ensure dignity and privacy are maintained and respected by staff and others.</p> <p>A restraint register is maintained and updated regularly. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as managing and supporting people with challenging behaviours. Staff interviewed understood the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	FA	<p>Review of resident's records evidenced the individual use of restraint is reviewed and evaluated during the six-monthly care plan evaluations, interRAI reviews and GP reviews. Families confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraint use is reviewed six monthly and an annual review of all restraints in use that includes all the requirements of the standard. Restraint use is reported by the restraint coordinator at the staff meetings. Minutes of meetings confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility. If any trends are identified this is fed back to staff. A six-monthly restraint</p>



		audit is completed with corrective actions implemented for any deficits identified.
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## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.