

Leslie Groves Society of St John's (Roslyn) - Leslie Groves Hospital

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 BSI Group New Zealand Ltd, 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:	Leslie Groves Society of St John's (Roslyn)
Premises audited:	Leslie Groves Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 12 July 2021 End date: 13 July 2021
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:	69

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

Leslie Groves home and hospital is operated by the St John's Parish (Roslyn) and cares for up to 71 residents requiring hospital level, psychogeriatric and dementia level care. On the day of the audit there were 69 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff, and the general practitioner.

The service has implemented an electronic quality and resident management system. An annual quality and risk management plan is in place identifying goals for the year.

The general manager has been in his role for 18 months and has previous experience in management roles. He is supported by a quality coordinator (registered nurse) who has been in her role for four months. There are three clinical unit managers, a team of registered nurses and long-standing healthcare assistants. The management team are supported by an external quality consultant, and an external health and safety consultant.

The residents, relatives and general practitioner spoke highly of the care and service provided at Leslie Groves Hospital.

This audit has identified the service meets the health and disability standards.

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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Leslie Groves has a philosophy to ensure that the residents' rights to privacy and dignity are recognised and respected at all times. There is a Māori health plan and cultural safety policies that guide staff in cultural safety, including recognition of Māori values and beliefs. There are policies and procedures around open disclosure. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Diverse beliefs, cultures, personalities, skills, and life experiences are acknowledged. Leslie Groves promotes and encourages good practice. There is evidence that residents and family are kept informed. A system for managing complaints is in place.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Key components of service delivery are linked to the quality management system. External contractors assist with quality and the health and safety programme. There is an implemented internal audit programme to monitor outcomes. Data collation occurs and is analysed for trends and results are discussed at facility meetings and corrective actions are implemented for any non-conformities. The staff training programme is implemented and based around policies and procedures. Annual resident and relative satisfaction surveys are completed.

Human resources are managed in accordance with good employment practice and meeting legislative requirements. All new staff completed a comprehensive orientation to the service. The service has sufficient staff allocated to enable the delivery of care. Residents and relatives stated staffing levels were sufficient to meet resident needs.

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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Leslie Groves provides information for residents and family/whānau prior to entry to the service. Residents are assessed prior to entry to the service. There is an electronic resident management system where care plans are developed with the resident. Family/whānau involvement is encouraged. Care plans where appropriate are evaluated six-monthly or more frequently when clinically indicated. There are a range of risk assessment tools and monitoring forms to assess effectively the level of risk and support required for residents. Medication management policies and procedures meet current guidelines. Annual competencies for medication administration are completed for all staff who administer medications. The GP completes three monthly medication reviews. Leslie Grove has a “magic table” which it has integrated into the activities programme. The activity programme has community-based events for residents which maintains their links with the community. A contracted food service provides the hospital’s site kitchen which transports meals to the rest home across the other side of the city. The kitchen provides all dietary requirements including modified diets and special foods. There are summer and winter menus which are reviewed by a dietitian.

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.
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Leslie Grove Hospital has a form 12A certificate of compliance due to the limitations of inspection for the building warrant of fitness. There is a reactive maintenance process as well as a planned maintenance schedule. The process for medical and electrical appliances is being completed. The residents' rooms are spacious with sufficient room to provide safe use of equipment and mobility aids. Leslie Grove has communal areas within the hospital and the psychogeriatric and dementia areas include lounge and dining areas as well as smaller seating areas. There are pleasant outside garden areas with suitable pathways, seating and shade provided. The laundry service does the personal laundry as well as the general items. The cleaning and laundry chemicals are safely and appropriately stored. Six-monthly fire drills are completed and there are policies and procedures in place for civil defence and other emergencies.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy that includes the use of enablers. A register is maintained for all residents with enablers. There were no residents using restraints and two residents documented as using enablers. Staff are trained in restraint minimisation and challenging behaviours.

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 surveillance programme is appropriate to the size and complexity of the service. The clinical unit manager for the hospital unit is the designated infection control nurse with support from the quality coordinator. The infection control programme is linked into the incident reporting system and logged onto the benchmarking programme quarterly.

The infection control manual outlines a comprehensive range of policies, standards, and guidelines. All infection control training is documented, and a record of attendance is maintained. Results of surveillance are acted upon and evaluated. Policies and procedures have been updated to include Covid-19 guidelines. Adequate supplies of personal protective equipment were sighted during the 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	45	0	0	0	0	0
Criteria	0	93	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>Leslie Groves has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. Staff have received training around the resident's code of rights in April 2021. Residents and relatives have been provided with information on admission which includes the Code.</p> <p>Staff interviewed (one general manager, one quality coordinator, three clinical unit managers, six healthcare assistants, three registered nurses (RN), three diversional therapists (DT) two cooks, one laundry assistant one housekeeper and the maintenance person) interviewed, confirmed staff respect privacy and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the</p>	FA	<p>Leslie Groves has an informed consent policy in place with systems in place to ensure residents, and where appropriate their family/whānau, are provided with information to make informed choices and decisions. There are informed consent policies/procedures and advanced directives in place. Specific consents are obtained for procedures such as influenza and Covid-19 vaccines with other general consents are obtained on admission.</p> <p>Nine resident files (four hospital, three psychogeriatric and two dementia) sampled, contained signed</p>

<p>information they need to make informed choices and give informed consent.</p>		<p>admission agreements and general consents. There were signed enduring power of attorneys as well as activation letters on resident files where required.</p> <p>At interview, caregivers interviewed demonstrated a thorough understanding of informed consent and the associated processes. On the day of the interview residents and family interviewed confirmed appropriate information had been provided and informed consent processes were in place.</p>
<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>	<p>FA</p>	<p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interview with the management team confirmed practice. Residents interviewed reported that they are aware of their right to access advocacy. All files reviewed in Ferntree (dementia) and Taieri (psychogeriatric) units had documents relating to EPOA. Psychogeriatric and dementia resident files reviewed included information on resident's family/whānau and chosen social networks. Residents and relatives interviewed identified that Leslie Groves provides opportunities for the family/EPOA to be involved in decisions and they are aware of how to access advocacy service. Staff interviewed could describe the role of the advocate and where pamphlets could be located around the facility.</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>	<p>FA</p>	<p>Residents and relatives interviewed confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans in files sampled. Residents and relatives interviewed verified that they have been supported and encouraged to remain involved in the community. There are regular outings to the community, church groups provide church services and there are regular entertainers who visit the facility.</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>	<p>FA</p>	<p>A complaints policy and procedure have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained since January 2020. There were five complaints logged in 2020, and five year-to-date in 2021. All complaints have been acknowledged, investigated and resolved in a timely manner. Correspondence is maintained with the complainant and is maintained on file. Residents and family members interviewed advised that they are aware of the complaints procedure and how to access forms.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The information pack provided to residents on entry includes information on how to make a complaint, and information on advocacy services and the Code. This information has been discussed with residents and/or family members on entry to the service. Large print posters of the Code and advocacy information are displayed in the facility. The admission agreement includes information around the scope of services, and any liability for payment for items not included in the scope and the Code. Complaint/ compliment forms are available in the reception area and around the facility.</p> <p>Resident meetings provide the opportunity to raise issues/concerns. Results from the 2020 satisfaction survey evidenced satisfaction around staff adherence of residents' code of rights in all of the units.</p> <p>Interviews with four hospital level residents and five relatives (two psychogeriatric (PG), two dementia, and one hospital) evidenced the registered nurses discussing the information pack with residents and family members on admission.</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>	<p>FA</p>	<p>Leslie Groves has a philosophy that ensures the residents' rights to privacy and dignity are recognised and respected at all times. Residents are encouraged to maintain their independence. Outings are encouraged and supported for the residents who are able. Staff interviewed stated that they encourage the residents' independence by encouraging them to be as active as possible.</p> <p>Healthcare assistants interviewed reported that they knock on bedroom doors prior to entering and ensure doors are shut when cares are being given and do not hold personal discussions in public areas. All the residents interviewed confirmed that their privacy is being respected. Residents with shared bathrooms have a privacy lock.</p> <p>Resident preferences are identified during the admission and care planning process with family involvement. The electronic resident files reviewed identified that cultural and/or spiritual values and individual preferences were identified on admission with family involvement, and these were documented in the resident's care plan. This includes cultural, religious, social, and ethnic needs. Staff have received training around abuse and neglect in March 2021.</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</p>	<p>FA</p>	<p>Leslie Groves is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There were no residents who identify as Māori on the day of the audit. The service has a Māori health plan and a cultural safety policy which includes cultural safety and awareness. The service has links with Otakou Marae. Staff receive education on cultural awareness during their induction to the service, ongoing cultural competency is completed using the online education platform. Discussions with staff confirmed their understanding of the</p>

<p>manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>different cultural needs of residents and their whānau. All staff completed training through the mauriora online training over March and April 2021. Leslie Groves also have access to cultural training through the Otago Polytechnic.</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 values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Internal audits are completed regularly around cultural safety. Healthcare assistants interviewed could describe learning about their residents and cultures, values, and preferences. The residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. Relatives interviewed confirmed they feel they are consulted and kept informed and family involvement is encouraged. The relatives' satisfaction surveys from the dementia and psychogeriatric units evidenced satisfaction that resident's spiritual and cultural needs were considered and being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The service has organisation-wide policies and procedures to protect consumers from any form of discrimination, coercion, harassment, or exploitation. Relevant policies and procedures have been implemented. Staff orientation and in-service education provide ongoing awareness around prevention of any discrimination, coercion and harassment.</p> <p>All staff interviewed, demonstrated a clear understanding of professional boundaries. Documented job descriptions describe the functions and limitations of each position.</p> <p>Relatives interviewed acknowledged the openness of the service and stated that they would be very surprised if there was any coercion or discrimination as staff were all approachable, welcoming and open. Interviews with the relatives from all units confirmed that staff treat residents with respect, and they are very skilled to manage anxiety and challenging behaviours.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service meets the individualised needs of residents with needs relating to hospital (geriatric and medical), dementia and psychogeriatric level care. The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. The recently employed quality coordinator has been orientated to the role by an external quality consultant, who also reviewed the quality systems. Evidence-based practice is evident, promoting and encouraging good practice. The service is proud of the high level of satisfaction evidenced in the satisfaction survey around service provision. There are good working relationships between the GP, nurse practitioners for Hospice and Southern District Health Board (SDHB) nurse practitioners. There has been a recent employment of a human resources manager, who has</p>

		<p>reviewed staff contracts to ensure legislative compliance is achieved.</p> <p>Physiotherapy services are provided on site, as required. A podiatrist is on site for eight hours every six-weeks. The service has links with the local community and encourages residents to remain independent. Residents and relatives interviewed spoke positively about the care and support provided.</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>There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not at the request of the resident) of an accident/incident. Fifteen incident forms reviewed from June and July 2021 identified family were notified following an incident. Interview with clinical unit managers, and RNs informed that family are appropriately notified following a resident change in health status. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. There was also evidence of family input into the care planning process and interRAI assessments, which was confirmed during interviews.</p> <p>The information pack and admission agreement included payment for items not included in the services. A site-specific booklet related to Leslie Groves Hospital provides information for family, friends and visitors to the facility. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The facility has an interpreter policy to guide staff in accessing interpreter services. There are no residents who currently require an interpreter.</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>Leslie Groves Hospital is owned and operated by Leslie Groves society of St John's (Roslyn). The board of 12 volunteers provide a governance role and meet monthly. The general manager and quality coordinator provide monthly reports to the board, and the general manager attends the board meetings.</p> <p>The service provides care for up to 71 residents at hospital (geriatric and medical), psychogeriatric and dementia level care. On the day of the audit, there were 69 residents in total: 30 residents in the 31-bed hospital unit, 16 residents in the 17-bed dementia unit, and 23 residents in the 23-bed psychogeriatric (PG) unit. One resident was in hospital during the audit. All residents were under the aged-related contract.</p> <p>The service is managed by a non-clinical general manager (non-practicing RN) who has been in his role for 18 months and has a background in health management and recruitment. The quality coordinator is a registered nurse, who has aged care experience. Each of the three units are led by clinical unit managers (registered nurses). Each unit manager has responsibility for their unit, with oversight from the quality coordinator and general manager. They are supported by an external quality consultant and an external health and safety contractor.</p> <p>The 2020 strategic plan and quality plans have been reviewed and the 2021 plans are being implemented. Goals have been set around health and safety service provision, resident satisfaction and the quality</p>

		<p>programme.</p> <p>The management team have completed at least eight hours of training related to management of a hospital in the past year.</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>In the event of the temporary absence of the general manager, the chairman of the board will provide management cover supported by the quality coordinator and clinical unit managers.</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>A quality and risk management programme is in place. The quality manual and the strategic, business/quality and risk management plans and procedure describe Leslie Grove's quality improvement processes. Quality goals are documented in the operations quality plan and are discussed at quality meeting. The service has comprehensive policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes which were signed by staff who were unable to attend. Staff interviewed were knowledgeable of the quality data and confirmed discussion around data and corrective actions during meetings.</p> <p>The monthly collating of quality and risk data includes (but not limited to) monitoring accidents and incidents, infection rates, restraint/enabler use and results of annual satisfaction surveys. Quality data is analysed for trends and is discussed at staff and management meetings, at the monthly board meeting, at handovers and displayed in the staff room. Internal audits regularly monitor compliance. A corrective action form is completed where areas are identified for improvement and included evidence of implementation and sign off. A quality improvement register/folder is maintained by the quality coordinator and lists the corrective actions and evaluates the progression towards completion.</p> <p>Annual satisfaction surveys are held which evidenced overall satisfaction with high satisfaction (88%) around staff being respectful, welcoming, kind, professional and understanding of residents' needs. There was high satisfaction around housekeeping and laundry. Corrective actions have been implemented for areas of low satisfaction.</p>

		<p>A health and safety programme is in place, with documented objectives for 2021. Regular reviews are completed at the monthly committee meetings. Leslie Groves has contracted an external consulting company to review the health and safety policies, procedures and the company has provided training for the committee members (representative of all departments). There is an implemented risk register which includes managing identified hazards which has been recently reviewed.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Interventions include (but are not limited to) increased monitoring, the use of sensor mats, chair alarms which clip onto residents clothing, but do not restrict movement, high/low beds, and pre-empting of residents' needs.</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>	FA	<p>The service collects all incident and accident information reported by staff the electronic system. Incident and accident data is collated and analysed monthly, and a report documented for the monthly quality, unit, and staff meetings. Fifteen resident-related incident forms were reviewed for June and July 2021. Each event involving a resident reflected a clinical assessment and follow-up by a RN, opportunities to minimise the risk of further incidents for that resident were identified and implemented (where possible), and neurological observations were completed appropriately for all unwitnessed falls where there was potential for a head injury. Healthcare assistants interviewed were very knowledgeable regarding the care needs (including high falls) for all residents. Discussions with the general manager and quality coordinator confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been 16 section 31 notifications sent since the previous audit for pressure injuries, change in management, a resident absconding and registered nurse shortages. The public health team were notified of the respiratory outbreak in April 2020 in a timely manner.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The recruitment and staff selection process require that relevant checks have been completed to validate the individual's qualifications, experience, and veracity. A copy of practising certificates is kept. Ten staff files (the quality coordinator, two clinical unit managers, two registered nurses, two diversional therapists, and three healthcare assistants) were reviewed and included all required documentation. Staff turnover related to care and service staff was reported as low. Registered nurse turnover has been higher, and analysis indicates this is related to external factors. The service is currently recruiting registered nurses.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. The quality coordinator is currently reviewing the role specific orientations as a quality initiative. Annual appraisals have been conducted for all staff whose files were sampled. A completed in-service calendar for 2020 exceeded eight hours annually, and the 2021</p>

		<p>education plan has been implemented. The management team and registered nurses attend external training including seminars and education sessions with the local DHB. Nine of eleven registered nurses including the quality coordinator, and three clinical unit managers have completed their interRAI training.</p> <p>Fourteen of sixteen healthcare assistants who work in the PG unit have completed the required New Zealand Qualification Authority (NZQA) dementia standards, two healthcare assistants have recently joined the unit. Eight of eleven healthcare assistants who work in the dementia unit have completed the required NZQA dementia standards, one healthcare assistant is in the process of completing and two staff are new to the unit.</p> <p>All healthcare assistants are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications. Currently there are five healthcare assistants who have completed level 4, seven who have completed level 3 and five healthcare assistants who have completed level 2.</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>Leslie Groves has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. In addition to the general manager who works full-time, there is a full-time quality coordinator (RN), three clinical unit managers and registered nurses who are rostered on 24/7. The on-call roster is shared between the three clinical unit managers.</p> <p>Cleaning staff are contracted over seven days a week. Staff reported that staffing levels and the skill mix were appropriate and safe. Residents interviewed advised that they felt there are sufficient staffing. The service is in the process of recruiting registered nurses and healthcare assistants.</p> <p>Leslie Groves hospital is divided into three units.</p> <p>The Redwood (hospital) unit has 31 beds with 30 hospital residents.</p> <p>The morning shift is covered by the clinical unit manager (RN) who works Monday to Thursday, and a registered nurse covers Friday to Sunday from 7 am to 3.30 pm. A registered nurse is rostered across all shifts. The registered nurses are supported by five healthcare assistants (HCAs) – all 7 am to 3.30 pm. The afternoon shift has a registered nurse and five healthcare assistants from 2.30 pm to 11 pm. There is one healthcare assistant and one RN who are rostered overnight.</p> <p>The Ferntree (dementia) unit has 17 beds and 16 residents and is overseen by the clinical unit manager Monday to Friday from 7 am to 3.30 pm. There is one enrolled nurse who works Monday to Wednesday mornings. They are supported by two healthcare assistants in the morning from 7 am to 3.30 pm, two healthcare assistants from 2.30 pm to 11 pm (currently recruiting for another HCA), and one HCA from 10.45 pm to 7.15 am. More experienced healthcare assistants are rostered over the weekends who hold first aid certificates and are medication competent.</p> <p>The Taieri (psychogeriatric) unit with 23 beds and 23 residents has a clinical unit manager Monday to Thursday and alternate Fridays from 7 am to 3.30 pm. There is a registered nurse who works the weekends</p>

		<p>and the alternate Fridays. There is registered nurse cover across all shifts. The registered nurses are supported by four healthcare assistants from 7 am to 3.30 pm, one healthcare assistant works Monday/Tuesday and alternate Sundays (due to availability) from 8 am to 1 pm. Afternoon shift has four healthcare assistants from 2.30 pm to 11 pm. Night shift has one healthcare assistant from 10.45 pm to 7.15 am. The registered nurse from Taieri unit oversees the Ferntree unit in the afternoon and night shifts.</p> <p>Extra RN and HCA cover is provided in the Taieri and Ferntree units when acuity increases.</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 files were appropriate to the service type. Residents entering the service have all relevant initial information recorded into the resident's electronic file within 24 hours of entry. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files were password protected from unauthorised access. Entries were dated and included relevant healthcare assistant or registered nurse, including designation. The electronic system demonstrated service integration of resident records.</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 Leslie Groves admission agreement meets the ARC and ARHSS contract and exclusions from the service are included in the admission agreement. There is information available for residents/families/whānau at entry and it includes (but is not limited to) advocacy, complaints, informed consent, and the Health and Disability Code of Rights. Residents are assessed by the needs assessment and service coordination (NASC) team before admission to Leslie Groves with an initial assessment completed at the time of admission. These were present in resident's files sampled.</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>The transfer/discharge/exit procedures include the use of a transfer/discharge form, and the completed form is scanned into the electronic file. Staff are available to escort residents if family are unavailable to assist with transfer, and copies of relevant documentation are forwarded with the resident.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Leslie Grove utilises an electronic medication system. The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Residents' medicines are stored securely in the medication room/cupboards. Registered nurses and healthcare assistants administer medicines. Medication administration practice complies with the medication management policy for the lunchtime medication round observed on the two days of the audit. All staff that administer medicines are competent and have received medication management training. Medicines are dispensed by the pharmacy using a robotically packed medication management system. The RN on duty reconciles the delivery and documents this. Temperature monitoring of the medication fridges and rooms was evidenced to be occurring as per policy. There were no residents self-administering medication on the day of audit. There are no standing orders. Eighteen electronic medication charts were reviewed. All medication charts had photo identification and an allergy status recorded. The GP reviews the medication charts at least three-monthly. 'As required' medications had indications for use documented and were administered appropriately with efficacy documented in the progress notes.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food services are provided by an external contractor in a commercial kitchen at Leslie Groves. A dietary assessment is completed by the RN as part of the assessment process, and this includes likes and dislikes. Residents are provided with modified diets and supplements as required and these requirements are documented in the care plan. This includes consideration of cultural needs.</p> <p>Fridge and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridge and freezers was covered and dated. The external contractor conducts audits as part of their food safety programme. Food is transported to each unit via hot boxes. Staff record the temperature of hot and cold dishes prior to serving. Resident and families interviewed were complimentary of the food service. Additional nutritious snacks are available over 24hrs in both the dementia unit and psychogeriatric units.</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</p>	<p>FA</p>	<p>Enquiries are taken by the administration team and passed to the nursing team. Prospective residents who are declined entry to the service are recorded on the declined entry form. If this does occur, then it is communicated to the potential resident/family/whānau and the appropriate referrer. Potential residents who are declined generally require a different service type.</p>

appropriate.		
<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>Nine files were reviewed in the three areas. The files for permanent residents have printed interRAI initial assessments and assessment summaries. Risk assessments are completed on admission and reviewed three-monthly as part of the care planning process. Additional assessments were used as required and their outcomes for management of behaviour, pain and wound care were reflected in the care plans.</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>Nine files were reviewed and these all had individualised long-term care plans that are comprehensive and demonstrated input from the care team and multi-disciplinary team as required. The resident care plans sampled were resident-centred and had detailed information to support the resident. The use of short-term care plans for acute health needs is evident. Three psychogeriatric and two dementia resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. The family members who were interviewed confirmed care delivery and support by staff meets their expectations and their involvement is well documented in the 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>Registered nurses (RNs) and HCAs follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse or wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to a variety of medical supplies (e.g., dressings). Continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and the healthcare assistants and RNs could describe this.</p> <p>Wound assessment, plans and evaluations were fully completed for all wounds. On the day of audit, there were six wounds, four of these were skin tears and two unstageable pressure injuries (one hospital, one PG). Both of the unstageable injuries have appropriate section 31 notifications. The GP and nursing staff were managing these pressure injuries, there was no current wound care specialist involvement. Education around wounds, and pressure injury prevention was completed in May 2021.</p> <p>Interviews with RNs and healthcare assistants demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted included behaviour charts, restraint monitoring forms, turning charts, food and fluid charts, regular monitoring of bowels and monthly weight management. The nurse practitioner for mental health of older person visits regularly. Strategies for the provision of a low stimulus environment could be described by RNs and healthcare assistants.</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 activity team at Leslie Groves includes one activities coordinator in training to become a diversional therapist, one activities coordinator and a van driver. Activities are provided from 9.30 am – 3.30 pm in the hospital unit, 10 am – 4 pm in the dementia unit and 11 am – 6 pm in the psychogeriatric unit. There is a Sunday programme provided by one of the diversional therapists. The activities team meets regularly with other local activities coordinators. Activities staff meet to plan the years activities.</p> <p>The activity programme is planned weekly and monthly to respond to spontaneous events that may occur. Activities planned for the day are displayed on noticeboards around the dementia, psychogeriatric and hospital areas. An activity assessment plan is developed for each individual resident based on assessed needs and individual abilities. Activity plans are reviewed six-monthly in the files sampled. Activities attended each day are recorded with progress note updates weekly and as required. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. Community group participation is evident in the programme. One-on-one time is provided for residents who are not able or choose not to join group activities. The group activities cover physical, cognitive, social, and spiritual needs. There are regular visiting entertainers and community group. There is a weekly church service and residents are able to attend church services in the community. Residents can go on outings using the service’s van which is shared between the two facilities.</p> <p>Leslie Groves’ activity programme is augmented by the implementation of a “magic table” Tovertafel. The ‘magic table’ has a range of programmes for different levels of ability. It is in a large room dedicated to its use by staff, residents, and their families. The magic table has been more especially useful for residents in the psychogeriatric area. It has facilitated a different way of communication for residents with staff but more particularly providing moments for families to share time and interact with residents in a different and more meaningful way than just visiting and sitting visiting with residents. Staff and families have experienced residents who have been nonverbal/nonresponsive, responding when fishing or chasing leaves on the ‘magic table”. As the room with the ‘magic table’ is not used as a public lounge it is available at times when residents in the psychogeriatric area or dementia areas are experiencing sundowning behaviours and the calming effect of programmes has meant that what can be a challenging time for residents and staff has become a quieter time which has a benefit to the overall management of residents.</p> <p>Resident meetings provide a forum for feedback relating to activities in the hospital unit. Feedback is received through discussions and conversations with family/whānau in the dementia and psychogeriatric unit. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. Caregivers were observed at various times involved throughout the day diverting residents from behaviours.</p>
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<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>All initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN three-monthly, using the interRAI tool and care plan or earlier for any health changes for files reviewed. Ongoing nursing evaluations occur as indicated and are documented within the progress notes or the care plan. Evaluations indicate whether the goal has been achieved or partially achieved. If the goal has been partially achieved, the RN documents progression towards meeting the goal in the electronic progress notes. The three-monthly multidisciplinary review involves the RN, GP, and resident/family mental health nurse practitioner and a palliative care specialist nurse attends if required. Family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits. The family are notified of the outcome of the review by phone call and if unable to attend.</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>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, and the resident was reassessed for a higher or different level of care. Discussion with the clinical unit managers and registered nurses identified there is access to a wide range of support either through the GP or district health board.</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>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets and products charts are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels and are stored correctly. Personal protective clothing is available for staff and was observed being worn by staff when they were carrying out their duties on the day of audit. Staff have completed chemical safety training.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Leslie Groves has a building systems status report (12A) issued by the city council declaring all emergency systems are safe and in working order. The building warrant of fitness could not be issued as essential checks could not be completed during the Covid-19 lockdown period. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and calibrated. Regular and reactive maintenance occurs. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn, and gardens. There are areas for residents to mobilise safely within the facilities. There are secure garden areas for residents in the dementia and psychogeriatric units.</p> <p>Healthcare assistants and RNs interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. The dementia unit has several areas designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required including individual rooms.</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>	<p>FA</p>	<p>The rooms are spacious with individual or shared ensuites. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. The communal toilets are well signed and identifiable and include vacant/in-use signs. Visitor toilet facilities are available.</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</p>	<p>FA</p>	<p>The resident rooms are spacious to meet the resident's assessed needs and were personalised. Healthcare assistants and the RNs interviewed stated rooms have sufficient space to allow cares to take place. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for residents.</p>

setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>In the three areas there are several lounge areas and dining room areas which are easily accessible for the residents. On the two days of the audit, activities were observed taking place in the lounges with other spaces used for activities such as the magic table. The dining rooms are spacious and located directly off the kitchen/servery areas. The furnishings and seating are appropriate for all resident's needs. Residents interviewed reported they are able to move around the facility and staff assisted them when required. The dementia and psychogeriatric units provide adequate space to allow maximum freedom of movement while promoting safety for those that wander, including dining and lounge areas.</p>
<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>All linen and residents personal clothing is laundered on site. The laundry assistant interviewed demonstrated the dirty in/clean out flow. There are chemical data sheets, instructions around management of infectious laundry to include Covid-19 precautions easily accessible. Chemicals in the laundry and housekeeping are provided by a closed system.</p> <p>The facility cleaning is provided by a contracted service. The staff member spoken to described routines and infection control measures implemented into the daily routines. The chemicals on the cleaning trolley were correctly labelled and the trolley is locked away when not in use. The housekeeper has attended chemical safety training and understood the extra precautions and chemicals required during the Covid-19 lockdown periods.</p> <p>The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings, and surveys. Residents and relatives interviewed during the audit were satisfied with the housekeeping and laundry services.</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>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, and gas cooking. Short-term backup power for emergency lighting is in place.</p> <p>There is a staff member on each duty that has completed first aid training. There are call bells in the residents' rooms, and lounge/dining room areas. Residents' rooms were observed to have their call bells in</p>

		close proximity.
<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>All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated with radiators and well ventilated. Residents and family interviewed, stated the environment was warm and comfortable.</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>Leslie Groves has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The clinical unit manager/RN is the designated infection control nurse with support from the quality coordinator and registered nurses. Infection control matters are discussed at registered nurse meetings. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</p> <p>There are signs visible to remind visitors not to visit if they are feeling unwell. Extra hand gels have been installed around the facility. All visitors are asked to sign in for contact tracing purposes.</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>There are adequate resources to implement the infection control programme at Leslie Groves. The infection control (IC) coordinator has been in the role since May 2021 and has previously completed infection control training internationally and is booked to attend the upcoming infection control conference in September 2021. External resources and support are available when required including (but not limited to): the infection control specialist at the DHB, the New Zealand Age Care Association (NZACA). Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facilities and alcohol hand gel is freely available throughout the facility.</p> <p>Covid-19 was well prepared for, adequate supplies of personal protective equipment were sighted in a centrally located cupboard. All units have isolation equipment available. There are Covid-19 resource folders easily accessible to staff in each unit.</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>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly by the external quality consultant. Policies, procedures, and the emergency plans have been reviewed and updated to include Covid-19 guidelines.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Education is facilitated by the infection control coordinator with support from the registered nurses. All infection control training is currently completed on a monthly basis. Competencies are completed around donning and doffing PPE, and handwashing, and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around outbreak management and infection prevention and control has been provided at least annually. Training around Covid-19 including hand washing and use of hand gels, donning and doffing personal protective equipment and coronavirus were provided and had high staff attendance. All units have a Covid-19 resource folder, which is easily accessible to staff. A debrief meeting was held after the 2020 respiratory outbreak.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual infection logs are maintained for each resident with signs and symptoms of an infection. The infection control coordinator collates monthly data from all three units, and analyses for trends. Graphs are produced by the electronic resident management system and benchmarked within the industry. The 2020 respiratory outbreak in the dementia unit was well documented, with logs maintained, daily updates were provided to staff. Staff interviewed felt they were well informed throughout the Covid 2020 lockdown levels</p>

programme.		and the outbreak.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Policies also include managing residents' challenging behaviours, alternatives to restraint and guidance for staff in responding to challenging behaviours and residents' needs. Leslie Groves has been restraint free in the psychogeriatric unit since 2018, with one restraint (hospital level) being identified at the previous audit, this is the highest the facility has reached with restraints. On the day of the audit, there were no residents using restraint and two residents using bedrails as an enabler. Both residents were interviewed and confirm the enabler was voluntary and in use only overnight. Enabler documentation for the two enablers included assessments, consents were signed by the residents on both occasions, interventions including risks were documented in the long-term care plans. Evaluations were documented three-monthly at the time of the medical review. Education is provided around restraint and enablers, and challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.