

# Sylvia Park Rest Home Limited - Sylvia Park Rest Home & Hospital

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## 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 Health and Disability Auditing New Zealand 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>	Sylvia Park Rest Home Limited
<b>Premises audited:</b>	Sylvia Park Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 31 May 2018    End date: 1 June 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	77

# 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.

### 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

Sylvia Park rest home and hospital is privately owned. The service is certified to provide rest home and hospital level of care for up to 81 residents. On the day of the audit there were 77 residents.

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

The owner/facility manager is supported by a general manager with accounting and human resource management experience. The full-time clinical manager has been in the role four months and has a background in aged care and rehabilitation.

The service has an established quality risk management system and policies and procedures to enable staff to deliver good care. Residents and family/whānau interviewed, commented very positively on the standard of care and services provided at Sylvia Park.

This audit identified improvements required around interRAI assessment timeframes, care plan interventions, implementation of care, aspects of medication documentation and restraint monitoring.

The service has achieved a continuous rating round communication.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Sylvia Park provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code and related services is readily available to residents and families/whānau. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed as per Right 10 of the Code. Residents and family interviewed, verified ongoing involvement with community.

## 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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Sylvia Park has an implemented a quality and risk management system that supports the provision of clinical care. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed met legislative prescribing requirements.

The diversional therapist and activities assistant provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. All bedrooms have ensuite toilets or full ensuites. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

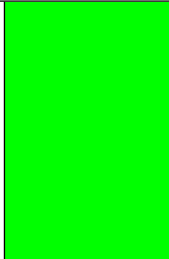
## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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The service has policies and procedures to appropriately guide staff around the use of enablers or restraints. A registered nurse is the restraint coordinator. The service currently has four residents assessed as requiring the use of restraint (bedrails) and seven residents with enablers (bedrails). Staff receive training in restraint and managing challenging behaviour as part of the education plan.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is the registered nurse. The infection control coordinator has attended external training. Staff attend annual infection control education. There is a suite of infection control policies and guidelines that meet infection control standards.

## 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)
<b>Standards</b>	1	44	0	3	2	0	0
<b>Criteria</b>	1	95	0	3	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Five healthcare assistants and three registered nurses (RN) interviewed, demonstrated their understanding of the key principles of the Code.</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>Informed consent processes are discussed with residents and families on admission. Written general consents including outings and indemnity forms, were included in the admission process as sighted in nine resident's files reviewed (seven hospital including one younger person with disabilities (YPD) and two rest home including one resident on respite care). Consent forms are signed for any specific procedures.</p> <p>Caregivers interviewed, confirmed consent is obtained when delivering cares. Advance directives sampled, identified the resident resuscitation status and/or signed by the resident (if appropriate) and the general</p>

		<p>practitioner.</p> <p>Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Eight admission agreements were sighted for the long-term residents. One resident was on short-term respite care.</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>	FA	<p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet (English and Chinese) on admission. Interviews with residents and family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main foyer. Discussions with family confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Interview with residents and relatives confirmed family and friends can visit at any time. Many families visit daily and are encouraged to be involved with the service and resident care. Residents are encouraged wherever possible to maintain former activities and interests in the community. The service has succeeded in supporting its residents to attend community events, churches and interest groups in the community to meet the cultural needs of the residents. There are regular visits to the Chinese Baptist church services followed by lunch. Due to the increasing frailty of some hospital residents the Chinese Baptist church are also holding worship meetings at the facility. The service has established strong links with the Chinese community that meets the needs of the residents.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The general manager leads the investigation of concerns/complaints consulting with the clinical manager for any clinical concerns/complaints. Complaints forms are visible for relatives/residents in the main entrance. The service has responded appropriately to two DHB complaints in April 2018 regarding documentation and communication. Corrective actions were developed and implemented and both complaints have been closed out. A complaint register is maintained. Relatives interviewed were aware of the complaints process and stated all staff and management are very</p>

		approachable. A complaints procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack that includes information about the Code and this is discussed during the admission process with the resident and family. The Code is also written in Chinese and available at the main entrance. Two residents (two rest home) and nine family members (two rest home and seven hospital) confirmed they received all the relevant information during admission. The relative and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There are policies in place to guide practice in respect of independence, privacy and respect. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and relatives interviewed, confirmed staff respect their privacy, and support residents in making choice where able. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. Staff receive training around abuse and neglect. Personal belongings are not used for communal use.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Sylvia Park has a Māori health plan to guide practice, including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Staff interviewed were able to describe how they would ensure Māori values and beliefs are met including the importance of family/whānau involvement. There were no residents that identified as Māori. The clinical manager is of Māori descent and attends the Māori nurse's organisation Hui's. She is available to advise staff on Māori protocol and cultural awareness if required.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The resident and family are invited to be involved in care planning, and any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews occur to assess if needs are being met. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs. Discussion with family and residents confirmed values and beliefs are considered. Residents are supported

		to attend church services of their choice. The service provides a culturally appropriate service by ensuring it understands each resident's preferences. The residents are predominantly of Chinese ethnicity and residents and relatives confirmed on interview their ethnic, cultural, spiritual values and beliefs are being met (link CI 1.1.12.2). The resident/relative satisfaction survey for meeting cultural needs was 100% very satisfied regarding communication.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Job descriptions include responsibilities of each role within the organisation. Copies of all employment documents are included in staff files. Staff complete signing and understanding around confidentiality, privacy, restraint and complaints on day one of their orientation. Qualified staff and allied health professionals practice within their scope of practice. Staff meetings include discussions on professional boundaries and concerns as they arise (minutes sighted). Interviews with the clinical nurse manager, RN and healthcare assistants (HCA) confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Policies and procedures meet the health and disability safety sector standards and are readily accessible to staff. All newly appointed staff work alongside a more experienced staff member during their orientation. Internal and external education occurs. Staff complete relevant workplace competencies. Facility meetings occur regularly (as sighted). Staff are kept informed on all facility and clinical matters. Registered nurses who have accepted "champion roles" (e.g., continence, wound, palliative care, infection control, restraint and Leecare) are offered training and support to carry out their roles, which includes staff education. Discussions with residents and family were positive about the care they receive.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	CI	There is a policy to guide staff on the process around open disclosure. Electronic accident/incident forms have a section to indicate if family have been informed of an accident/incident. Fifteen of 33 incident forms reviewed for April 2018, identify family were notified following a resident incident/accident. The clinical manager confirmed family are kept informed. The relatives interviewed, confirmed they are notified of any incidents/accidents. There are monthly resident meetings open to families to attend. Newsletters are sent out to families keeping them

		<p>informed on facility matters and upcoming activities.</p> <p>Families and staff provide translation for residents of Chinese culture who do not speak English. Residents and families are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. The service has exceeded in meeting the standard around communication for its residents and families.</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>	<p>FA</p>	<p>Sylvia Park rest home and hospital provides care for up to 81 rest home/hospital level of care residents. There are 79 dual-purpose beds and two rest home beds. On the day of audit there were 11 rest home residents including one resident on respite care, and 66 hospital residents which included one resident under 65 years of age.</p> <p>Sylvia Parks mission and philosophy underpins the business plan, quality goals and nursing objectives. The annual business plan identifies objectives, timeframe and responsibility. The 2017 business plan and goals have been evaluated with achievements documented including; a) installation of an electronic resident record system, b) electronic finger print scan sign in/out system, c) landscaping of the front and back areas and extending the car parking, d) ongoing refurbishment of resident rooms, and purchase of equipment, including 12 air alternating mattresses, platform scales and four hoists, and e) installation of an electronic resident record system.</p> <p>Sylvia Park is privately owned by two owner/directors (non-clinical) for over 20 years. The general manager has been in the role for 10 years and has a qualification in accounting and commerce. He is responsible for daily operations of the service, non-clinical services, human resource management, maintenance and health and safety.</p> <p>A full-time clinical manager/RN was appointed in February 2018. She has had previous aged care experience and has been involved in DHB medical and rehabilitation services.</p> <p>The owner/director and general manager have attended at least eight hours of education including DHB cluster meetings, and aged care conferences. The clinical manager completed orientation with the owner/director and a senior RN on employment.</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>	<p>FA</p>	<p>The owner/facility manager and general manager provide cover for each other's absence. A senior RN provides cover for the clinical managers leave.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Sylvia Park has a current quality and risk plan in place. There are policies and procedures manuals available for all staff. The policies have been developed by an aged care consultant and meet accepted good practice. Staff interviewed confirmed they are made aware of new/reviewed policies and sign to state they have read them.</p> <p>Quality data including accidents/incidents, infection control, concerns and complaints, restraint, internal audit, survey outcomes, quality goals and quality improvements are discussed at the facility meetings. There are monthly management meetings, staff meetings, clinical and service meetings. Meeting minutes are available to all staff. Staff interviewed stated they are kept informed on facility and clinical matters.</p> <p>There is an internal audit schedule that includes environmental, support services and clinical audits. Corrective action sheets are raised for any audit result less than 100%. Corrective actions reviewed have been discussed at the relevant facility meeting. Corrective actions are signed off when completed.</p> <p>An annual resident/relative survey is completed in May each year. May 2018 results show 92% resident/relative satisfaction in comparison with 72% in May 2017. Results were fed back to participants.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The health and safety representative (general manager) has completed stage one of the health and safety training and update to the legislation taken by the aged care consultant. There is a current hazard register that has been reviewed annually and updated to include identified hazards and controls for the relevant area. Health and safety is discussed at the staff meetings.</p> <p>Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Analysis of falls include time and location, fall</p>

		prevention includes the use of sensor mats and hip protectors. The physiotherapist (contracted 16 hours a week) is involved in resident initial assessments on admission and ongoing treatment. The service employs a physiotherapy assistant full-time, to carry out walks and exercise programmes as directed by the physiotherapist. The clinical manager (previously a falls champion with the DHB) is clinically focused to reduce falls. The service is currently trialling 10 rooms of frequent fallers with wall sensors. Improvements made to manual handling and falls prevention is a positive quality initiative by the service.
<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>All incidents/accidents are entered onto the electronic system. Data generated identifies the type of incident, time and location of incident. Electronic progress notes evidence 15 of 33 accident/incident records that identify RN timely clinical assessment and follow-up. Three of three unwitnessed falls did not have neurological observations completed as per protocol (link 1.3.6.1). There is documented evidence of relative notification of incidents/accidents. Relatives interviewed confirmed they are informed of any changes to the resident health.</p> <p>The service collects incident and accident data and reports aggregated figures to the management and staff meetings. Staff interviewed confirmed incident and accident data are discussed at the staff meeting and information and graphs are made available.</p> <p>Management are aware of the requirement to report all essential notifications to the relevant authority. The MOH was notified following a change in clinical manager. There have been no outbreaks.</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>There are human resources policies to support recruitment practices. Nine staff files sampled (one clinical manger, three RNs, three HCAs, one activity coordinator and one cook) contained all relevant employment documentation. Current practising certificates were sighted for the RNs and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Appraisals are completed annually.</p>

		<p>The 2017 education planner has been completed as per schedule. The 2018 education programme is in progress. Staff attend on-site education and have the opportunity to attend aged care residential study days and palliative care courses. The aged care consultant provides some on-site training and the physiotherapist takes staff through manual handling training. Staff complete competencies relevant to their role.</p> <p>Care staff are currently progressing through Careerforce units with an external assessor.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staff and relatives interviewed confirmed there are sufficient numbers of staff on duty to deliver safe care.</p> <p>Level one is 40 beds currently with four rest home and 33 hospital level residents and level two is 41 beds with seven rest home and 33 hospital level residents. Each level is divided into three wings. On morning shifts on both levels there are six HCAs who work the full shift in pairs. On the afternoon there are three full shifts and two short shifts on level one and two full shifts and two short shifts on level two with a full shift "floater".</p> <p>There is a RN on level one and level two on morning and afternoon duties. The one RN on night shift covers both levels. The clinical manager and general manager are on-site Monday to Friday and on-call 24 hours.</p> <p>There are five activity coordinators each day from 9.30 am to 3.30 pm.</p> <p>There are two dedicated cleaners/laundry staff each day.</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>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Individual resident files demonstrate service integration, including records from allied health</p>



		<p>professionals and specialists involved in the care of the resident.</p> <p>Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Entries into the electronic records are identifiable by name, date, time and designation.</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 service has policies and procedures in place to manage residents' entry into the service. Admission information packs on the services for rest home and hospital level care, are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed (for long-term residents) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement.</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>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service.</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>	PA Low	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses an electronic medication system. RNs that administer medications have been assessed for competency on an annual basis and attend annual medication education. Senior caregivers who act as second checker have also completed medication competencies annually. All medication is checked on delivery against the medication chart. All medications are stored safely in the upstairs and downstairs clinical rooms. The medication fridges are maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There was one resident self-medicating on the day of audit (herbal medication). Self-medication competencies had been reviewed three-monthly.</p> <p>Eighteen medication charts were reviewed; the three-monthly GP reviews were not always documented as up-to-date. Appropriate practice was demonstrated on the witnessed medication round.</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>All meals at Sylvia Park Rest home and Hospital continue to be prepared and cooked on-site. There is a four-weekly seasonal menu, which had been reviewed by a dietitian and the food control plan is currently in the process of being verified. A 'dumb waiter' is used to transport food between the floor levels. The temperature of the food is checked before leaving the kitchen. There are food covers available. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met. There is an English and a Chinese menu.</p> <p>Staff were observed assisting residents with their meals and drinks. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services. Food satisfaction is discussed at residents' two monthly meetings.</p> <p>Residents and family members interviewed were very complimentary about the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. The dishwasher is checked regularly by the chemical supplier.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety.</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>	<p>FA</p>	<p>The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. The management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>An initial assessment and care plan are completed on admission and these were evidenced on all nine resident files, including the respite resident. All long-term residents had current electronic assessments and interRAI assessments (link to 1.3.3.3). Resident needs and supports were identified through available information such as assessments, interRAI, discharge summaries, medical notes and in consultation with significant others (link to 1.3.5.2).</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Resident files and electronic care plans reviewed were resident focused, however not all current assessed needs were fully addressed in the care plan. Short-term care plans were not always used for changes to health status, however, examples of short-term care plans were sighted in a range of resident files (link to 1.3.6.1 for short-term care plans and monitoring). Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. The resident on respite care had all identified needs included in the respite care plan and the YPD resident had interventions documented in the care plan that were specific to their needs as a younger person.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>There is documented evidence on the family/whānau contact form in each resident file that indicates family were notified of any changes to their relative's health, including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health. When a resident's condition alters, a registered nurse initiates a review and if required, a GP review. Acute changes to care and monitoring needs were not always documented.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were for in place for residents with wounds, including two residents with stage two pressure injuries.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences.</p> <p>Monitoring forms are used for weight, vital signs, and blood sugar levels, pain, challenging behaviour, food and fluid charts but were not</p>

		always completed.
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs a diversional therapist (DT) that works Monday to Thursday who has been in the role for five years. Four physiotherapy assistants/activities assistants assist with providing exercise programmes and activities for the residents.</p> <p>The programme is Monday to Friday and integrated to meet the physical and psychosocial well-being of the residents. The programme includes new activities when requested by residents and is varied. The activities programme observed on the days of audit was culturally appropriate for the residents in the home and included Chinese singing, Mah-jong and other card games, which were very clearly enjoyed by the residents. Resident and staff all described Cantonese opera which are favourites. Activity planners are posted on noticeboards in English and Mandarin.</p> <p>Special events such as birthdays, Chinese New Year, Lantern Festival and Mother's Day are celebrated by residents, families and staff. Photos of these celebrations are on the walls in the lounges, and the residents are able to watch Chinese TV channels.</p> <p>There are regular outings into the community. The service has a van for regular outings. Activity staff have current first aid certificates.</p> <p>One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated. The specific needs of the younger resident are documented and addressed on a one-to-one basis.</p> <p>A resident assessment is completed with the family and resident on admission. Individual activity plans were seen in long-term resident files and are currently in the process of being transferred onto the computer. The DT is involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through two monthly resident meetings and direct feedback from residents and families. Residents interviewed spoke very positively about the varied activities programme which they have input into.</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>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 six monthly or earlier for any health changes for long-term residents. The evaluation process is documented through the electronic care planning system as well as the interRAI process (link 1.3.3.3). Examples of short-term care plans in use were sighted for acute changes in care (link 1.3.6.1). Family had been invited to attend the care plan review and informed of any changes if unable to attend. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</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 resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</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 for chemicals are readily accessible for staff. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when 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>The building holds a current warrant of fitness. There are two lifts and stair access between the two floors. One lift can accommodate a bed/ambulance stretcher. The general manager undertakes preventative and reactive maintenance. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours.</p> <p>The facility has wide corridors with sufficient space for residents to</p>

		<p>safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade is provided.</p> <p>The HCAs and RNs stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All residents' rooms except two bedrooms have ensembles. These two rest home rooms share a toilet and have a hand basin in their rooms. There are adequate numbers of communal toilets and showers. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Privacy is maintained at all times (observed). Residents interviewed confirmed care staff respect the resident's privacy when attending to their personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are spacious. There is adequate room to safely manoeuvre mobility aids or hoists. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms, which included the residents own furnishing and adornments.</p>
<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>There are lounges of varying sizes in each area. This enables residents to have quiet time or socialise in small groups. Each area has a dining room. All lounge/dining areas are accessible and accommodate the equipment required for residents. Residents are able to move freely and safely, and furniture is arranged to facilitate this. There is adequate space to allow for individual and group activities to occur. All communal areas are accessible to residents. Healthcare assistants assist to transfer residents to communal areas for dining and activities as required.</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>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff. There is a defined clean/dirty area within the laundry. Laundry chemicals are stored in a locked cupboard. There were adequate linen supplies sighted. Laundry and cleaning staff have attended chemical safety training. Cleaning and laundry audits have been completed. Residents and staff expressed satisfaction with the cleaning and laundry service.</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>	<p>FA</p>	<p>Emergency and disaster policies and procedures are documented for the service. There is an evacuation scheme that has been approved by the fire service 16 July 2009. Fire drills occur every six months. The orientation programme and annual education/training programme include fire and emergency preparedness training. A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water (underground water tank) and emergency civil defence supplies which are all checked regularly. A gas BBQ is available for alternate cooking. There is emergency lighting.</p> <p>A call bell system is in place, including all resident rooms and communal areas. Residents were observed in their rooms with their call bell in close proximity. The building is secure after hours with all external doors alarmed and the doorbell linked to the call bell system. There are CCTV security cameras and sensor lighting around the building. There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid certificate.</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>	<p>FA</p>	<p>Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. Resident room temperatures are monitored through a central computer system. The residents and family interviewed confirmed temperatures are 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>	<p>FA</p>	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer. The infection control officer is a registered nurse with a job description. The infection control programme is linked into the quality management system and reviewed annually, last in January 2018.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents. Hand sanitisers are available throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to</p>	<p>FA</p>	<p>The infection control coordinator is an experienced RN new to the role, and supported by the clinical manager. The infection control</p>

<p>implement the infection control programme and meet the needs of the organisation.</p>		<p>coordinator is registered to complete on-line infection control training.</p> <p>Infection control reports are provided monthly to the staff meeting. The infection control coordinator has access to an infection control nurse specialist at the DHB, external infection control consultant, public health, laboratory and GPs.</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>There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These have been developed by an aged care consultant and readily available to all staff. The infection control policies link to other documentation and cross reference where appropriate.</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>The infection control coordinator is responsible for coordinating and providing education and training to staff. The orientation package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs annually as part of the training calendar.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</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 programme.</p>	<p>FA</p>	<p>The infection control policy includes a surveillance policy including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are entered into the electronic resident system and collated on a monthly basis. Graphs are displayed with monthly and annual comparison and identify trends and corrective actions. The infection control coordinator provides infection control data, trends and relevant information to the management and clinical meetings, infection control committee and clinical/quality meetings. Infection control audits are completed, and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility.</p> <p>There have been no outbreaks.</p>



<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers. The service currently has four residents assessed as requiring the use of restraint (bedrails) and seven residents with enablers (bedrails). Residents voluntarily request and consent to enabler use.</p> <p>Staff receive training around restraint minimisation that includes competency assessments. Staff receive training around managing challenging behaviours. A RN nurse is the restraint coordinator.</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>	<p>FA</p>	<p>A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is a registered nurse. All staff are required to attend restraint minimisation training annually. Restraint is discussed at the RN and care staff meetings. Residents and relatives receive information on restraint use.</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>	<p>FA</p>	<p>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. Three of four hospital level residents' files where restraint was being used were selected for review. Each file included a restraint assessment that identified risks associated with the use of the restraint, however, the risks were not reflected in the resident care plan (link 1.3.5.2). Consent forms viewed had been signed by the resident's family.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Low</p>	<p>A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint, however, not all monitoring forms had been completed at the required frequency.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint use is reviewed monthly by the restraint coordinator and reported at the monthly staff meetings. Restraint evaluation forms include a risk questionnaire and includes discussing whether continued</p>

		use of restraint is indicated.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint programme, including reviewing policies and procedures, internal audits and staff education is evaluated annually by the restraint coordinator.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>Sylvia Park has policies and procedures in place to ensure safe medication practice. They have transferred over to an electronic medication system and are working with GPs to ensure they are documenting and prescribing appropriately on the system; this is in progress. Witnessed medication administration by staff was safe and followed good practice.</p>	<p>The electronic reporting for medication, reports that of the 77 residents, 25 did not have an up-to-date GP review of medications documented. The service is working with the GP to assist them to register reviews on the system.</p>	<p>Ensure that the GPs document three monthly medication reviews.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames</p>	PA Low	<p>All long-term resident files reviewed have an up-to-date interRAI assessment documented. However, not all assessments have been assessed within timeframes. The</p>	<p>Two new admissions this year did not have an interRAI assessment completed within timeframes. Two residents (, one hospital, one rest home resident) have not had an interRAI reassessment</p>	<p>Ensure that interRAI assessments are documented within set timeframes.</p> <p>60 days</p>

that safely meet the needs of the consumer.		eight long-term resident files all had a long-term care plan in place and all had been documented and reviewed within timeframes.	completed six monthly within the last year.	
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>The service is working hard to fully implement an electronic care planning and assessment system. Not all care planning interventions were fully documented on the electronic system, or short-term care plans. Interviews with HCAs and RNs evidenced a high level of knowledge regarding care needs by staff. Interviews with relatives and residents also evidenced that they all felt that care needs were addressed by all staff. Six resident files (three on restraint and three with enablers) were reviewed and did not document risks associated with the use of bedrails as restraints and enablers.</p>	<p>(1) Four of seven hospital level files reviewed did not include all interventions for resident care. Examples include; (i) One care plan had no interventions to manage a resident's increased oral secretions and the occasional need for suction, (ii) one did not have interventions for safe smoking, and an agreement for care interventions with the resident, (iii) one did not have repositioning guidance for staff (only documenting 'appropriate positioning') and (iv) one did not document the need for a higher level of monitoring due to falls risk.</p> <p>(2) One of two rest home level files did not include all interventions for resident care, this care plan did not include interventions for management of behaviours that challenge.</p> <p>(3) The risks associated with restraints and enablers were not documented in six resident care plans reviewed (three restraint and three enablers).</p>	<p>(1)- (2) Ensure that all care needs are documented in the care plans.</p> <p>(3) Ensure all risks associated with restraint/enabler use is documented in the care plans.</p> <p>60 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Wounds care plans are in place for all residents with wounds. Staff interviewed were familiar with the care requirements for each resident and described the care and monitoring needs for all resident files reviewed. Staff were observed providing care and monitoring, however, this was not well documented. Not all acute monitoring and care needs were included in short-term care plans or updated on long term care plans. Neurological observations were not always documented for unwitnessed falls as per the service policy.</p>	<p>(i) One rest home resident with an infected eye had no interventions documented in a short-term care plan or the long-term care plan updated and no documented evidence that the care was being implemented. Upon review the resident, eyes appeared to be clear of infection and the caregiver described the eye care provided. (ii) One hospital resident had no interventions documented in a short-term care plan or long-term care plan updated regarding GP advice to monitor a rash and no documentation to evidence this was occurring. (iii) One rest home resident did not have monitoring documented for two hourly turns and fluid monitoring; (iv) one rest home resident did not have all behaviours exhibited, documented on the behaviour monitoring form. (v) One hospital resident did not have monthly weights constantly documented. (vi) Three of three residents who had an unwitnessed fall did not have neurological observations documented.</p>	<p>(i)-(ii) Ensure interventions to support acute changes to care are documented either in a short-term care plan or updated to the long-term care plan. Ensure documentation reflects these have been implemented. (iii) – (v) Ensure monitoring charts are completed as directed by the care plan; (vi) Ensure where residents potentially have hit their head that neurological observations are completed and documented.</p> <p>60 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its</p>	<p>PA Low</p>	<p>Three care plans reviewed on the electronic resident system of residents with restraint, identified the use of restraint and monitoring frequency. Restraint monitoring forms on the electronic resident system had</p>	<p>Three of three resident restraint monitoring forms had not been completed at the required monitoring frequency.</p>	<p>Ensure restraint monitoring is completed at the required timeframes.</p> <p>90 days</p>

<p>outcome, and shall include but is not limited to:</p> <ul style="list-style-type: none"> <li>(a) Details of the reasons for initiating the restraint, including the desired outcome;</li> <li>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</li> <li>(c) Details of any advocacy/support offered, provided or facilitated;</li> <li>(d) The outcome of the restraint;</li> <li>(e) Any injury to any person as a result of the use of restraint;</li> <li>(f) Observations and monitoring of the consumer during the restraint;</li> <li>(g) Comments resulting from the evaluation of the restraint.</li> </ul>		<p>not been completed at the required monitoring frequency.</p>		
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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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	CI	<p>The service ensures there is good communication both verbal and written for 75 of 77 residents who identify with Chinese culture and do not speak English.</p>	<p>The owner/directors and manager are of Chinese ethnicity and fluent in their language. They communicate with residents and their families during the admission process ensuring they are aware of the services available and any additional charges not included in the admission agreement. All important information is translated into Chinese and displayed, including the Code of Rights, informed consent, fire signs, sign/in out visitor book, complaints policy and forms. The menu boards have both English and Chinese menus displayed. The activities board have the activities written in English and Chinese. The Chinese television channel is available on residents' individual TVs and in the lounge TVs. Many of the staff speak several languages including English, Cantonese and Mandarin. Staff interviewed who do not speak Cantonese or Mandarin, stated they have learned basic words and use sign or body language to enable them to communicate with Chinese residents. The service rosters at least one staff member on each shift who can communicate with the residents in their language and assist other staff to understand the resident needs/requests. The resident/relative satisfaction survey for communication was 100% very</p>

			satisfied regarding communication for its Chinese and European residents. The service has exceeded the standard around communication with residents and relatives.
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End of the report.