

Heritage Lifecare Limited - Coldstream Rest Home & 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Coldstream Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 May 2019 End date: 7 May 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	52

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

Coldstream Rest Home & Hospital provides hospital and rest home level care for up to 58 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

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

This audit has resulted in no areas requiring improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is provided to residents and family members at the time of entry to services. The rights described in the Code are upheld during service delivery. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

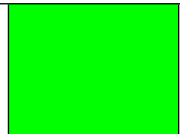
Systems are in place to enable any residents who identify as Māori to have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

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

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident and family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information. Separate personalised activity plans are included. Any new problems that arise are integrated into the care plan. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Six enablers and two restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews

occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme is led by an infection control coordinator, who has access to specialist infection prevention and control for further information and advice when needed. There is a focus on infection prevention and safe management of any infections that occur. Review of the infection prevention programme is described in policy documentation.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education and handwashing competencies.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Heritage Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code) that are used at Coldstream Lifecare. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing annual mandatory training, as was verified in training records.</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>Registered nurses and caregivers who were interviewed understood the principles and practice of informed consent. Informed consent policies and procedures provide relevant guidance to staff.</p> <p>Clinical files reviewed showed that Heritage Lifecare informed consent forms had replaced former documents and demonstrated informed consent has been gained appropriately. The clinical nurse manager described how some residents and family members require more explanations than others. Signed forms on the person's choices around resuscitation were on file and demonstrated GP involvement. Enduring power of attorney documentation was in all files viewed. There was limited evidence of advance care planning; however, there were reports of planning under way to encourage more residents to consider such options. Staff were observed to gain consent for day to day care and to</p>

		consistently provide choices.
<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>During the admission process, residents are given a copy of the Code, and a copy of the separate brochure on the Nationwide Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. There were no examples available about the involvement of Advocacy Services, although there were many examples provided of family and friends acting as an advocate for residents.</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>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. A family/ whānau record sheet provides a date and an overview of key conversations with family/whānau.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they feel welcome when they visited and are comfortable in their dealings with staff. Residents informed that friends and family are always welcome and come at times that suits them, so long as it is reasonable.</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>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that four complaints had been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within accepted timeframes. Action plans showed any required follow up and improvements have been made where possible. The care home manager (CHM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>	FA	<p>Residents and family/whānau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) at the time of admission and were familiar with the contents. A copy of the Code is inside wardrobe doors. The clinical services manager informed it</p>

<p>their rights.</p>		<p>is a key part of the initial discussions and reminders are offered to residents and staff at appropriate opportunities including meetings. The Code is displayed in the main entrance in both English and te reo Maori together with information on advocacy services, how to make a complaint and feedback forms. Copies of brochures about the Code are supplied in the enquiry package, the family package and at the front entrance.</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>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Some family members provided examples.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room and the clinical services manager stated that although staff are frequently reminded of the importance of maintaining privacy and confidentiality that no formal reminders have been needed.</p> <p>Residents are encouraged to maintain their independence as per personal preferences and abilities. Some are encouraged to walk to the dining area, others supported to go out to community events, such as a club or church, and others encouraged to attend activities or assist with their personal hygiene. Care plans included documentation related to the resident's abilities and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. Family/whānau informed they had not seen any examples of concern.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There are not currently any residents who identify as Māori. The clinical services manager informed that several staff who identify as Māori would support any residents who identify as Māori and are admitted to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. A kaumatua who was available to provide advice and support to residents and staff is no longer available and the facility manager described actions taken to date since March 2019 to ensure a suitable person is available for this role should it be required and to provide staff training on the principles of the Treaty of Waitangi.</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>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Personal preferences expressed by residents, required interventions and special needs were included in the care plans reviewed with additional information on those identified within their social profiles and activities plans. A family member described additional efforts staff have gone to while ensuring their relative's cultural values are met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that there has been no evidence of any form of discrimination, harassment or exploitation and people said they believe they are safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the 'Heritage Way', which is the organisation's Code of Conduct. All employees are required to sign 'the Heritage Way' to conform they have read and will honour it. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The managers could not recall any such incidents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the DHB aged care palliative nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the staff were responsive to medical requests and were experts in wound care. Advanced skills around wound care were further described by registered nurses as they described how healing had occurred for wounds that were expected to remain chronic. The clinical services manager expressed pride in the overall commitment of staff in the care and support they provide, which was reiterated by residents and family members/whānau.</p> <p>Staff reported they receive management support for external education and access relevant professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the focused orientation schedule and comprehensive ongoing training schedule, including 'toolbox talks'.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported by documentation in family/whānau contact</p>

<p>provide an environment conducive to effective communication.</p>		<p>records filed in residents' records reviewed. Enduring power of attorneys are involved as indicated in each resident's file. Staff understood the principles of open disclosure, which is supported by organisational policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this had never been required due to all residents being English speaking. Some staff are bi-lingual or multi-lingual and would assist with interpretation if necessary. A list of interpreter services for different languages is available in the nurses' station for use when necessary. Staff were reported to be creative when dealing with people with hearing impairment and are taught how to manage hearing aids.</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>Heritage Lifecare Limited (HLL) strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. There are Coldstream specific documents that describe annual objectives and the associated operational plans. A sample of monthly reports to the support office showed adequate information to monitor performance is reported including occupancy, staffing, key performance indicators, emerging risks and issues.</p> <p>The service is managed by a CHM who holds relevant qualifications and has been in the role for 18 months at Coldstream. She has previous management experience, including at Coldstream under the previous owner. Responsibilities and accountabilities are defined in a job description and individual employment agreement. She confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through sector meetings and HLL conference and education seminars. The CHM is supported by the clinical service manager (CSM) and HLL support office. A member of the support office was onsite during the audit.</p> <p>The service holds contracts with Canterbury District Health Board (CDHB) for hospital, respite, long term chronic conditions and rest home care and Ministry of Health for young persons with a disability (YPD). The service also has one resident under an accident compensation corporation (ACC) contract. Fifty-two residents were receiving services under the contracts at the time of audit. Twenty-two rest home residents, including one YPD, twenty-nine hospital level including two YPD. One ACC resident.</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</p>	<p>FA</p>	<p>When the CHM is absent, the CSM carries out some of the required duties under delegated authority, or the support office provides interim cover. During absences of key clinical staff, the clinical management is overseen by a registered nurse (RN) who is experienced in the sector and able to take responsibility for any clinical issues that may arise. The CHM is a registered nurse and assumes some CSM responsibilities. Staff reported the current arrangements work well.</p>

<p>which ensures the provision of timely, appropriate, and safe services to consumers.</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>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of key performance indicators, clinical incidents including infections.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management, quality team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and feedback via surveys. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed a comment regarding food temperatures and laundry. There was evidence in residents' and staff meeting minutes that actions have been implemented and residents reported improvements.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The CHM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager was familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the HLL support office via the electronic system.</p> <p>The CSM and CHM described essential notification reporting requirements, including for pressure injuries. They advised there have been two notifications of significant events made to the Ministry of Health, since the previous audit. One is closed out and one is still being investigated.</p>
<p>Standard 1.2.7: Human</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of</p>

<p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month and annual period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A contractor is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of four weeks of roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</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>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Some of these details are also entered electronically by administration staff when a resident enters the service.</p> <p>Clinical notes were current and integrated with GP and allied health service provider notes. A separate folder holds working documents of wound care plans, short term care plans and behaviour monitoring records to ensure updating occurs. InterRAI assessment information entered into the Momentum electronic database was also up to date for all residents. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being transferred to a secure area of a nearby facility. No personal or private resident information was on public display during the audit with residents'</p>

		main service plan and associated documents stored in lockable cupboards in the nurses' station.
<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>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with an enquiry pack that contains written information about the service and the admission process. The organisation seeks updated information from relevant sources such as the GP for residents accessing respite care. On entry to the service a family pack is provided. This contains information on rights, advocacy services, information on making a complaint, a welcome letter and information on cultural, advocacy and interpreter services.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort and transport made available as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. It was reported that there is open communication between all services, the resident and the family/whanau with one person relaying their experience. At the time of transition between services, appropriate information is reportedly provided for the ongoing management of the resident and will include medication records. All referrals are documented in the progress notes.</p> <p>Although a rare occurrence, if a person transfers to another long-term care facility, the registered nurse provides a verbal and a written handover and the person is accompanied by a staff person, or a family member is asked to accompany them.</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</p>	FA	<p>The medication management policy and procedures are current and identify all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. There are three levels of medicine management competency; registered nurse, caregiver competency and second-checker. All staff who</p>

<p>guidelines.</p>		<p>administer medicines are competent to perform the function they manage, and this was confirmed in records sighted.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Due to the distance from the pharmacy these are couriered and signed for on receipt. A registered nurse checks the medications against the prescription and enters this into the person's electronic record. All medications sighted were within current use by dates. Clinical pharmacist advice is provided on request, otherwise they visit to undertake six-monthly checks of controlled medicines. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries, as well as six-monthly pharmacy stocktakes.</p> <p>The records of temperatures for the medicine fridge were within the recommended range.</p> <p>Good prescribing practices were evident within the electronic system with dates recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. All medicine records that were checked at audit had been reviewed by the GP within the past three months. With the electronic medicine management system in place, standing orders nor faxed medicine records are no longer needed. However, instructions around warfarin doses, may be faxed or emailed by the GP.</p> <p>There is currently only one resident who self-administers a medicine; this being an inhaler. Appropriate processes are in place to ensure this is managed in a safe manner and records of a current competency that has been reviewed within the last three months were sighted.</p> <p>An implemented process for comprehensive analysis of any medication errors via the incident/adverse event reporting process is in place.</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>The food service is provided on site by a qualified cook and kitchen team and is in line with recognised nutritional guidelines for older people. A four-week rotating menu follows summer and winter patterns and has just been reviewed by a qualified dietitian (2019). The winter menu commenced 1 May 2019.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local district council and has an expiry date of 2 March 2020. Arrangements are in place for an audit of the food control plan to occur within the next month. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Likewise, equipment checks such as fridge and freezer temperatures and cleaning schedules are checked daily. The food services manager has undertaken a safe food handling qualification, with kitchen assistants</p>

		<p>completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The registered nurse supplies the kitchen with a copy of these records, including when there are any updates or changes require. The personal food preferences, any special diets and modified food texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, such as lipped plates are also noted. Information from these documents is transferred onto a master list for the kitchen team, a copy of which was sighted.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There has only been one person whose entry application was declined, and the facility manager discussed the situation with the NASC. Examples of a person being incorrectly assessed were discussed and reassessments had been undertaken within two to three weeks before transfer to a suitable facility. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Documented information in relation to the validated nursing assessment tools for falls risk, pressure injury risk, skin integrity, nutrition, continence, oral health and manual handling was consistently available in all files sample. The information identified areas in which additional attention might be required for that person. The sample of care plans reviewed had an integrated range of resident-related information obtained from external sources including hospital visits, GPs and family members.</p> <p>A record of the status of interRAI assessments was downloaded and confirmed all residents have a current interRAI that has been completed by one of the on-site trained interRAI assessors. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery</p>	FA	<p>The care plan sections of the service delivery plans reviewed all reflected the personal support needs of residents. There was evidence that the needs and information identified in the resident's interRAI</p>

<p>plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>assessment and other assessment processes on record had been used to assist in the development of the care plans. Care and support plans reviewed showed evidence of updates inserted since their initial development indicating changes in the person's needs.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans with some people specifically affirming that they believed they were listened to.</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>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. Observations included viewing multiple examples of actions taken by the caregivers that demonstrated they were very familiar with the needs of the individual residents. Staff listened to requests from residents and ensured their safety when mobilising them or assisting them in some way. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision.</p> <p>The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high level. Particular mention was made of the registered nurses, in particular the clinical nurse manager, and their skills in wound management. Care staff confirmed that care was provided as outlined in the documentation. In most instances they use handover to ensure they have the latest information and will ask a registered nurse if they are uncertain about anything.</p> <p>A range of equipment and resources was available, all of which was suited to the level of care provided and in accordance with the residents' needs. Manual handling assessment and care plans were in each person's plans with acknowledgement of independence when this is the case.</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>A trained diversional therapist who holds a national Certificate in Diversional Therapy, has been in the role for just over a week. During interview, it was evident that this person is skilled and creative with innovative ideas for moving forward. On the day of audit, an interim activities coordinator who had previously worked in the role for many years, was assisting with the diversional therapist's orientation. One of the care givers assists the diversional therapist on two afternoons of the week. The relief activity person informed all staff are good at assisting with activities and/or getting people back and forward to activities. Community volunteers also assist with the activities programme or provide entertainment as applicable.</p> <p>On admission, a personal profile that includes a social assessment and history is undertaken to ascertain</p>

		<p>residents' needs, interests, abilities and social requirements. A preferred activities/recreation form is completed alongside at least two goals and an outline of interventions. This is accompanied by a 24-hour activities plan. Records on file demonstrated all documentation was up to date including three-monthly reviews of each person's activities goals. Participation records were being filled in for each person. Activities assessments are reviewed every three months to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are also evaluated as part of the formal six-monthly care plan review.</p> <p>An activities schedule for the current week was sighted, as was a draft for the upcoming four weeks. A variety of individual, group activities and regular events were evident in the schedule with an inter-rest home quiz at the local church on day two of the audit. Residents are involved in evaluating and improving the programme through residents' meetings. Family members may provide feedback on the programme at any time, otherwise it is a question in the satisfaction surveys. Residents interviewed confirmed they find the programme interesting, that it has a lot of variety and that there is always something new to try.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to one of the registered nurses. Monitoring processes for ongoing problems were also evident and specific examples included for pain and for behaviours that challenged.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of such changes were evident in the care plans reviewed.</p> <p>Copies of short-term care plans showed these are being consistently reviewed and progress is evaluated as clinically indicated depending on the issue of concern. Examples of currently active short-term care plans were for infections and wounds. The clinical services manager described examples of concerns that had started in a short-term care plans and been transferred into the long-term care plan. Evidence of this having occurred was evident in the care plans reviewed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress. Such reviews/evaluations can be informal, formal or opportunistic.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Residents may choose their medical practitioner and a number of different GPs attend residents in Coldstream Lifecare. If the need for other non-urgent services are indicated or requested, the GP or clinical services manager sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to occupational therapy, physiotherapy, dental services, older person's health</p>

<p>referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>psychiatric services, outpatient services and an ostomy clinic. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, by contacting the GP practice for direction; or sending the resident to accident and emergency in an ambulance, depending on the circumstances. The clinical services manager stated that the resident has a right to refuse a referral and provided an example. An escort is provided as needed and a family member informed that they may be contacted to assist their relative to an appointment when needed.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>A current building warrant of fitness (expiry date 01 May 2020) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes ensuite rooms and communal facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment and accessories are available to promote resident independence.</p>

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<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>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids and wheelchairs. Staff and residents reported the adequacy of bedrooms.</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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</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>Laundry is undertaken on site in a spacious laundry or by family members if requested. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff undertake training as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and</p>

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 18 Feb 2014. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 15 January 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for full occupancy of residents. Water storage tanks are located around the complex, and there is a generator available for hire if required. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto outside garden. Heating is provided by either electric panel or ceiling heaters in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, which is supplied by the support office. The infection control policy and procedures regarding implementation of the infection control programme were reviewed April 2019.</p> <p>In the absence of the designated infection control coordinator/registered nurse, the clinical coordinator/registered nurse was interviewed regarding the infection prevention and control programme. The role and responsibilities of the infection control programme are defined in a job description. Infection control matters, including surveillance results, are reported monthly at the quality improvement and risk management team meeting. This committee includes the facility manager, the clinical services manager, the infection prevention and control co-ordinator, the health and safety officer, and representatives from food services, maintenance, the laundry and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Influenza vaccinations are offered to residents and staff may get them free</p>

		of charge. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The recently appointed infection prevention and control coordinator is supported by the clinical services manager and by the local DHB infection prevention and control nurse, who has appropriate skills, knowledge and qualifications for the role. Specific training to upskill the infection prevention and control coordinator has been scheduled for 10 June 2019. Additional support and information are accessible from the infection control team at the DHB, the community laboratory, the GP and the public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The clinical services manager confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies have been updated as required with the most recent one being around implementation of the programme. The documents include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Infection control is on the list of mandatory trainings. A session on hand washing competency was provided to staff by the infection prevention and control coordinator in March 2019. The DHB infection control nurse provided a broader session in May 2018 and the clinical services manager is waiting on a laboratory to confirm training dates for October 2019. Content of the training is documented and evaluated to ensure it is relevant, current and</p>

		<p>understood. A record of attendance is maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, or advice about remaining in their room if they are unwell. A resident interviewed was aware of the need to drink additional fluids to avoid urinary tract infections.</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>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. Staff initially document all infections on an infection control data form, on which a care plan is developed alongside. The infection prevention and control coordinator reviews all reported infections and develops recommendations as relevant. This is currently being done by the clinical services manager. New infections and any required management plan are discussed at handovers, to ensure early intervention occurs.</p> <p>The information is entered into a monthly data form and into the infection register. It is then reported to the support office each month as part of the key clinical indicators report. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Comparisons are made with data from the previous year. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Data is benchmarked externally within the group; however, Coldstream Lifecare does not yet have 12 months of data available.</p> <p>There have been no outbreaks to report over the past 12 months.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and responsibilities.</p> <p>On the day of audit, two residents were using restraints and six residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff.</p>
<p>Standard 2.2.1: Restraint</p>	FA	<p>The restraint approval group made up of the CHM, CSM and the general practitioner (GP), are</p>

<p>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>responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/EPOA. The restraint coordinator described the documented process. Families confirmed their involvement. The GP is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example the use of sensor mats and low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group</p>

of restraint.		<p>meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality and staff meetings. Minutes of meeting reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with CSM confirmed that the use of restraint has been reduced over the past year. Restraint use is benchmarked within HLL and this confirmed restraint use is below average.</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.