YHKT LIMITED - Kintala Lodge

Introduction

This report records the results of a Provisional Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity: YHKT LIMITED

Premises audited: Kintala Lodge

Services audited: Dementia care

Dates of audit: Start date: 6 May 2019 End date: 7 May 2019

Proposed changes to current services (if any): Proposed purchase of facility.

Total beds occupied across all premises included in the audit on the first day of the audit: 16

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.

General overview of the audit

Kintala Lodge Rest Home (Kintala) continues to provide secure dementia rest home level care for up to a maximum of 30 residents. This service is operated by Liberty 2000 Limited – Kintala Lodge Rest Home and managed by a general manager with the support of a clinical nurse who is a registered nurse. Families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations of residents and interviews with family, management, staff, and a general practitioner. The prospective purchaser/provider was interviewed via 'Skype' during the audit. The prospective owner has a New Zealand degree (major in Accounting and Commercial Law), has worked as an accountant since 2007 and in 2009 qualified as a New Zealand Chartered Accountant. The facility is currently privately owned and the sale of the business is expected to occur in September 2019. The audit was conducted to

establish how well prepared the prospective provider understands their responsibilities to provide a health and disability service to meet the standards, how they plan to ensure residents' needs are met and to determine their understanding of the Age Related Residential Care contract requirements with the Waikato District Health Board.

This audit has resulted in no areas identified for improvements.

Consumer rights

Staff demonstrated good knowledge and practice in relation to respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Families interviewed expressed satisfaction with the caring manner and respect that staff show towards each resident.

There were two residents who identified as Māori residing at the service at the time of audit. There are no known barriers to residents accessing the service. Services are planned to respect the care required, culture, values and beliefs of all the residents as individuals and as a collective.

Written consents are obtained from the residents' families/whānau, enduring power of attorney (EPOA) or appointed guardians, when necessary.

Residents are encouraged and supported to maintain strong community and family links.

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

Organisational management

The strategic and business plans include the scope, direction, goals, values and mission statement of the organisation. Services monitoring provided to the governing body is regular, effective and includes quality and risk. An experienced and suitably qualified person manages the facility with clinical support.

Quality and risk management plans are in place and include collection and analysis of quality improvement data which identifies trends and leads to improvement. Staff interviewed confirmed that they were involved in quality and risk planning and monitoring processes. Adverse events are documented, monitored and corrective actions are implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and regularly reviewed.

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.

Management of consumer information meets the required standard.

Continuum of service delivery

Pre-admission information clearly and accurately identifies the services offered. The service has policies and processes related to entry into the service.

Residents are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops a care plan specific to the resident. This is developed with the resident, family and existing community supports and health care professionals. When there are changes to the resident's needs a short-term plan is developed and integrated into a long-term plan, as needed. The service meets the contractual time frames for all short and long-term care plans. All care plans are evaluated at least six monthly. All residents have 'interRAI' assessments completed and individualised care plans related to this programme.

Residents are reviewed by their GP on admission and assessed thereafter once a month depending on their health status and needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

Activity coordinators provide planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes accommodated. The service has a four-week rotating menu which is approved by a registered dietitian. Resident's nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

Safe and appropriate environment

The facility meets the needs of residents and was clean and maintained. There is a current building warrant of fitness. Electrical equipment is tested annually. 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 and this is easily available throughout the facility. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken on-site and evaluated for effectiveness through the internal audit processes.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Call bells are available in residents' rooms and in communal areas. Security is maintained.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. There are no enablers in use at the facility given the residents' inability to provide informed consent. Three restraints ('safe seat' lap-belts) are in use at the time of audit. A comprehensive assessment, approval and monitoring process is in place with regular review. Medical personnel are involved in the restraint approval process. Staff demonstrated a good knowledge and understanding of their responsibilities in restraint assessment and monitoring processes.

Infection prevention and control

The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors.

Relevant education is provided for staff, and when appropriate, the residents and their families.

There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported to staff, family and visitors where appropriate.

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	100	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The service has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). 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 training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The clinical nurse/RN and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Five of five

		residents' files reviewed showed evidence that the enduring power of attorney for the resident had been enacted. In the instance where there was no EPOA, the court had been appointed. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, family members are provided with information on the Code and the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential and remain as independent as possible and to maintain links with their family. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints management process is clearly described in the policy document. Advocacy and staff education on complaints management are included in the policy. The documented procedures are clear and meet the requirements of this standard, the provider's contract with the DHB (ARC contract) and Right 10 of the Code. Information on the complaint process and available advocacy is provided to residents and families on admission through the admission agreement and information provided on entry to the service. The sighted complaints register contains sufficient detail about complaints received since the previous audit (eg, dates, descriptions, investigations, and outcomes). There has been one complaint received since the last audit. Action taken, through to an agreed resolution was documented and completed within a short timeframe. Action planning is in place following any complaint and historical entries showed that the

		required follow up and improvements have been made after any complaint The GM is responsible for complaints management and follow up. There have been no complaints received from external sources since the previous audit. Staff are informed about the complaints process during induction and they are reminded about this at staff meetings. All staff interviewed confirmed a good understanding of the complaint process and what actions are required. Relatives interviewed confirmed they are informed about the complaints system and would have no hesitation in raising concerns.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Families interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in the main foyer areas together with information on advocacy services, how to make a complaint and feedback forms. Prospective provider interview May 2019 – The prospective provider is new to the aged care sector, however when interviewed, had a good understanding of consumer rights. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the requirements of the Code.
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	Residents' families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room and/or share a room with another person with the family member's consent and this was acknowledged in the written admission agreement. Residents are encouraged to maintain their independence by participating in activities of their choice. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. 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. 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.
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	Staff support residents in the service who identify as Māori 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 are no barriers in supporting residents who are admitted to the facility who identify as Māori. The clinical nurse interviewed reported that that there are two residents who affiliate with their Māori culture. There is a current Māori health plan developed with input from cultural advisers. All values and beliefs are acknowledged with the support of the Te Whare Tapa Whā model and evidenced and integrated into long-term care plans. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Staff, residents and whānau are also supported by a Māori Liaison person who is a senior caregiver at the facility and a volunteer who visits once a week. Throughout the facility there are signs written in Māori to acknowledge different areas/rooms and furniture. Whānau interviewed reported that staff acknowledge and respect their individual cultural needs. A quality initiative to review how Māori culture can be incorporated more into everyday living for residents at the facility and to ensure that residents that affiliate with their Māori culture have access to appropriate services is currently in place and supported by a cultural adviser from the local community. Early feedback shows positive feedback from whānau, and staff are observing that residents are participating more in activities with some challenging behaviour noted in residents to have reduced.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	Families verified that they were consulted on the behalf of their family member in relation to their individual culture, values and beliefs and that

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed. The family satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. The clinical nurse/RN had records showing required training on professional boundaries. 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, psychogeriatrician, mental health services for older persons, diabetes/practice nurse and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included knocking on doors before entering residents' rooms and day to day discussions between residents, staff and families.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Family members interviewed 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 in residents' records reviewed. Staff understood the principles of open disclosure, which is

		supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English. Staff are able to provide interpretation as and when needed and they use family members. One resident was identified as having a significant sensory impairment. Appropriate equipment, resources and allied support was evident in the resident's long term care plan (eg, support with mobility and meals and staff introducing themselves when approaching the resident). A current quality initiative to support families with resources and information about dementia is in place. Early feedback from families has been positive and 'appreciated'.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. Quality and risk management, vision and mission statements are documented and reviewed annually as part of the business planning process. A sample of the reports provided to the directors showed adequate information to monitor performance is reported. Progress against goals is monitored by the general manager (GM) who meets bi-monthly with the other director and co-owner. Outcomes from these meetings are documented and showed that all areas of service provision are discussed along with a detailed report provided by the RN. The service is managed by a GM who has been in the role for eighteen years. The GM described knowledge of the sector, regulatory and reporting requirements and maintains currency through the MoH Bulletin, DHB updates, aged residential care forums, employment and other legislative requirement briefings. The GM and second in charge registered nurse are on site five days a week and, between them, they cover the facility during the evenings and weekends. Both have many years' experience in the provision of dementia care. Records showed that the GM and the RN are attending education appropriate to their roles. Family members interviewed confirmed their satisfaction with all areas of service delivery and the ways in which their relative's needs are

		being met. The service holds contracts with the Waikato DHB and ACC for Aged Related Residential Care, Residential Respite Services and Long-term Support Chronic Health Conditions (Residential). Sixteen residents were receiving services at the time of audit. Prospective provider interview May 2019 – The prospective provider stated that she intends to maintain the current quality programmes and reporting systems to meet the current policies and procedures which meet the ARRC and legislative requirements. She confirmed understanding of the required skill mix to ensure dementia level care residents' needs are met. The current general manager will be onsite to support the new owner in the first four weeks of transitioning. All other staff will be retained to meet the needs and acuity of all residents. A discussion has occurred between the current director and strategy and funding manager for the Waikato district health board, however formal notification of the proposed purchase had not occurred at time of audit.
Standard 1.2.2: Service Management 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.	FA	When the GM of the facility is absent, the registered nurse carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well and that they felt supported by the facility manager and registered nurse. Prospective provider interview May 2019 – The prospective provider has no plans to make any significant staff changes during the transition period. Existing cover for provision of dementia level care and is currently researching the Age Residential Related Care (ARRC) agreement, including responsibilities of an ARRC manager to meet section D17 of the agreement.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement and is well understood and implemented by staff. This includes management of audit activities, a

quality and risk management system that reflects continuous quality improvement principles.		regular resident satisfaction survey, complaints, hazards, and clinical incidents including infections and incidents/accidents. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at management team and staff meetings. Staff reported their involvement in quality and risk management activities through the staff meetings and through audit feedback activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey feedback showed that most respondents were either satisfied or very satisfied with the services provided at the facility. Policies reviewed cover all necessary aspects of the service and contractual requirements; they 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. The system includes regular internal auditing, reporting incident/accident and health and safety matters, review of restraint and infection control data and complaints management. The GM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented its requirements. Corrective actions from the audit process are implemented when there are service deficits. All reporting is linked to management processes through the director's bi-monthly meetings and to staff via the monthly staff meetings. This information is used to inform ongoing planning of services to ensure residents' needs are met. The service wide approach to risk management includes analysing incident reports, hazards, and other checks (through the audit process) to identify and communicate ongoing risks. Staff are being kept updated about any actual or potential risks by the GM, RN care planning activities and via handovers. This was confirmed in meeting minutes sighted and verified by staff interviewed. Quality indices (eg, falls and infections) are benchmarked by an offsite organisation against other like facilities.

		Prospective provider interview May 2019 – During the four-week transition phase, the new provider will use the existing facility's policies and procedures. The new provider interviewed stated that they intend to develop and provide a quality management system which will include the required internal audits and any changes that will be occurring.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Staff document adverse any near miss events on an incident form. The RN collates all incidents monthly according to the number and type of incidents and where and when these occur. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Detail of disclosure to families was evident on the forms as well as input from the resident's GP. Adverse event data is collated, analysed and reported to the directors of the facility and to the staff at staff meetings. The service is benchmarking fall rates and infection data with other similar services. There have been no notifications of significant events made to the Ministry of Health since the previous audit. The GM described essential notification reporting requirements and, although there were no residents with pressure injuries on site during the audit days, the GM and RN both understood the reporting requirements should they occur. Prospective provider interview May 2019 – There are no known legislative or compliance issues impacting on the service. The prospective owner stated that they are currently researching the required health and safety legislation to meet the DHB and contractual requirements and are aware of the need to comply with these.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Review of human resources management policies and procedures, five personnel records, the organisational chart, and interviews with staff and the general manager reveals good employment processes in accordance with relevant legislation. The recruitment process includes referee checking, police vetting and validation of 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. 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 during a three-month period. Continuing education is planned on a biannual 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 staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. 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 and completion of annual performance appraisals. The staff files and interviews with care staff confirmed that the recruitment and orientation processes are planned, coordinated and effective. Orientation initially includes a series of practical and theoretical teaching sessions with follow up competency tests and questionnaires. Once the initial orientation is completed the new employee works with a 'buddy' for a period of time until they are competent to work independently. The staff file of the RN showed that the RN has a current APC. The general manager verifies other registered health practitioners are authorised to practice before allowing them to provide services. APCs for associated health professionals (GP, pharmacy and podiatry) were on file. All care staff and the RN have either attained the required qualifications in dementia education or commenced training for this. In-service training is planned a year ahead and includes a range of subjects specifically related to caring for residents with dementia. Certificates sighted confirmed that the facility RN has completed interRAI training and the annual competency test.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery (guided by the MoH safe aged care and dementia staffing guidelines), 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet changes in occupancy and acuity. The GM and an RN are on site Monday-Friday during the day and an afterhours on-call roster is in place. Two caregivers are rostered for every duty (one of which is a senior caregiver) and staff report that there is good access to advice available to them when needed. Care staff reported there were adequate staff available and that they were able to complete the work allocated to them. Residents and family interviewed reported that they were happy with the level of service provided. Activities, kitchen, and domestic staff are allocated sufficient hours to provide services. Observations and review of a four-week 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. Prospective provider interview May 2019 – The prospective owner intends to employ another registered nurse to the service to support and maintain the current staffing levels and skill mix and will use the facility's existing staffing policies and procedures. In the first four weeks of transition after the sale the current general manager and clinical nurse will be providing onsite support. The prospective provider stated that they are currently researching the required contractual obligations to be met when delivering dementia level care services.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely off site and were observed as readily retrievable using a cataloguing system on the day of audit. Residents' files are held for the required period before being destroyed.

		No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	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. The five residents' files reviewed showed that all residents had been assessed by a psychogeriatrician. Enduring power of attorney (EPOA) for the resident had been enacted and consent for the resident to be admitted into dementia level care had been given. The prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from NASC and GP for residents accessing respite care. 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 demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. There have been no recent acute hospital admissions.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.

guidelines.		A safe system for medicine management using a paper-based 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. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly. 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. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used. Vaccines are not stored on site. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by one of two cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was last reviewed by a qualified dietitian on the 19 September 2018. Recommendations made at that time have been implemented. 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 Hamilton City Council and expires 29 March 2020. The kitchen had a verification audit with an 'acceptable outcome' on the

		12 December 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Both cooks have undertaken a safe food handling qualification. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by family interviews and day to day observation of residents eating their meals. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	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 whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional, incontinence screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one trained interRAI assessor on site who is the clinical registered nurse. Families confirmed their involvement in the assessment process.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Residents' files reviewed included information to support staff with challenging behaviour demonstrated by residents including the triggers and interventions for the behaviour. Care plans evidence 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. Families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is 'very good'. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme is provided by an activities co-ordinator training to become a diversional therapist who works Monday to Friday 10.00 am – 3.00 pm. There is currently no diversional therapist based at the facility, however the activity co-ordinator has support and guidance from a diversional therapist/tutor in the community who holds a National Certificate in Diversional Therapy. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated daily and as part of the formal six-monthly

		care plan review. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Staff have access to activities to support residents at any given time. Families/whānau and residents are involved in evaluating and improving the programme through satisfaction surveys and day to day discussions. Activities are specific to the needs and abilities of people living with dementia. Activities are offered at times when residents are most physically active and/or restless, such as music and one to one interaction.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. 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 short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access referrals to other health and/or disability service providers. Although the service has a 'house doctor', families may choose for their family member to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to mental health services for the older person, psychogeriatrician. The resident and family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and

		emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The safe and appropriate storage and disposal of waste, infectious or hazardous substances is described in policy, as is storage and use of chemicals. Staff follow documented processes for the management of waste and infectious and hazardous substances. Care and domestic staff interviewed demonstrated awareness of safety issues around managing waste and hazardous substances. An external company is contracted to supply and manage chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, a 'spills kit' is available for use in an emergency and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this. Body waste and continence products are observed being disposed of with staff wearing appropriate personal protective equipment (disposable aprons and gloves).
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The interior and exterior of the facility is well maintained and is fit for purpose. A current building warrant of fitness (expiry date 1 December 2019) is publicly displayed. There is access for residents to secure outdoor gardens and recreational areas including for those who use mobility support equipment. Efforts are made to ensure the environment is hazard free to promote resident safety and independence. There have been no incidents or accidents related to the external environment. The front door is keypad secure. Corridors, toilets and bathrooms have appropriately installed handrails. Residents have are assisted in identifying toilets through the use of large print and directional signage with brightly coloured doors to delineate the space and promote independence. There are no hoists on site. Electrical testing and tagging is completed by a certified electrician annually and records showed this was completed in 2 May 2019. All fire safety equipment is checked monthly by an external service agency. Calibrations of scales and medical

		equipment occurs annually. Records showed this occurred on 4 April 2019. Audit documents reviewed, confirmed that environmental inspections occur bi-annually, and maintenance requests are attended to as soon as possible. There is evidence that hazards are reported. Visual inspection revealed that external areas are safe and meet the needs of the resident group. Seating is safe and suitable for older people. Shade is available to allow for sufficient shade for sitting outdoors in the summer; this was recently removed for the winter months (externals fixings for the shade were observed). The transportation of resident's policy contains fully described and detailed information which is directly related to the safe transporting of residents. Residents are accompanied off-site either in the care of their family or with one of the facility staff members present. Prospective provider interview May 2019 – highlighted that there are no planned alterations to any buildings or facilities.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	The facility has an adequate number of easily accessible toilets and showers. There are two bathrooms, five toilets and seven hand basins and one designated staff/visitor toilet area. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Observation confirmed that privacy was respected by staff when accompanying residents to attend to their personal hygiene needs. Each toilet and shower room is clearly identified by different coloured doors, diagrams and directional arrows. Hot water areas accessed by residents is tested weekly to ensure it is delivered at a safe temperature. Water temperature records show no temperatures over 43 degrees. The GM described a process to ameliorate any variances that may occur through changes to the thermostatic control of the water and tempering valves.

Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single or shared accommodation and are generously sized. Where rooms are shared the arrangement is discussed with family and they sign their consent and agreement to room sharing. Rooms are personalised with furnishings, photos and other personal items and there is a wardrobe in each room to store personal clothing. The beds and bed linen are being continually updated and observation of the linen being used showed it to be in good condition. There is room to store mobility aids and wheelchairs within the residents' rooms and communal areas.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Services at Kintala Lodge are provided in a discreetly secure locked environment which is appropriate and necessary for resident safety. Residents have access to external gardens which are secure and safe. The home is spacious with internal and external walking areas for residents. Residents were observed walking freely though the facility. There are two recreational areas for residents; one is which is designated as a dining area. The dining and lounge areas are spacious and enable easy access for residents and staff, including the residents using mobility aids. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Cleaning and laundry policies and procedures including job descriptions, and scheduled tasks are clearly described and known to staff. Laundry is undertaken on-site in a dedicated laundry area. Staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Interviews with staff demonstrate that efficient and effective systems are in place for cleaning and laundry. All areas in the home were kept clean and hygienic. Relatives expressed satisfaction with the services provided. Chemical training was evident in staff files. Chemicals were in a secure area and stored in a lockable cupboard and in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit

		programme and the latest satisfaction survey indicated that satisfaction levels were 'good' or 'very good'.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	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 described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was last approved by the New Zealand Fire Service in 2012. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 17 April 2019. Fire suppression systems are checked monthly by an external service. The orientation programme includes fire safety education and training. Staff confirmed their awareness of the emergency procedures and what they need to do in the event of a fire. The RN and most of the care staff have current first aid certificates (two are awaiting refresher training to take place shortly). Adequate supplies are available for use in the event of a civil defence emergency, including food, water, blankets, lighting, mobile phones and gas BBQ's to meet the requirements for residents. A large water storage tank is located in the grounds of the facility and this is cleaned and refilled bi-annually. Emergency lighting is regularly tested and was observed to be working during the audit. Call bells to alert staff to residents requiring assistance are accessible and within easy reach. Call system audits are completed on a regular basis. During the audit staff were observed to be attentive to the needs of the residents. There were few call bells and these were responded to promptly. Appropriate security arrangements are in place and the families of new residents are given education on the importance of this. Exit doors and windows are checked in the evening. Staff say any security incidents would be reported; there have been none.
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows.

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		Communal areas have doors that open onto outside garden areas. Underfloor heating is provided in residents' rooms in the communal areas and are controlled by thermostat. Areas were observed to be warm and well ventilated throughout the audit. Family members interviewed stated the home is maintained at a safe and comfortable temperature.
Standard 3.1: Infection control management 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.	FA	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, with input from the GP. The infection control programme and manual are reviewed annually. The clinical nurse/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the general manager and tabled monthly at full staff meetings. 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. 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.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for 11 years. She has undertaken training in infection prevention and control and attended relevant study days and meetings/discussion groups with other aged care providers, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.

Standard 3.3: Policies and procedures 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.	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2018 and include appropriate referencing. 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.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Education with residents is generally on a one-to-one basis and has included support with handwashing and increasing fluids during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/clinical registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover to ensure early intervention occurs. Short-term care plans are developed. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the

		surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the clinical nurse and reported to the general manager and all staff. Eighteen residents consented to the flu vaccine in 9 May 2018. The facility has had a total of 28 infections since November 2018 up until and including April 2019. There were no infections recorded for December 2018. Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked externally. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. There have been no infectious outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints. Processes for assessment, approval and consent, monitoring and review, evaluation, cultural considerations, de-escalation and staff training are clearly described. Enablers are not used in the facility. The restraint coordinator (who is the RN) provides support and oversight for restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. On the day of audit, three residents were using restraint. Review of the restraint register clearly showed that restraint intervention is minimised and only used for safety reasons, when absolutely necessary, and when all alternatives have been explored. The restraints in use during the audit period were 'safe seat' lap belts to prevent falls in high falls risk residents, and where other interventions have been unsuccessful. The facility also has a well described policy on understanding and managing challenging/difficult behaviour in relation to dementia and this is understood by staff. The restraint register also showed evidence of review and discontinuation (in one instance) of restraint when this was no longer required to maintain safety.

		Review of the three residents' records revealed that processes are adhered to and interview with the restraint coordinator demonstrated a thorough knowledge and understanding of the requirements related to restraint. Staff understanding is tested by the completion of questionnaires at least bi-annually. Information on the provider's philosophy of restraint minimisation and management of challenging behaviour occurs at orientation and is discussed during staff meetings. Ongoing education is mandatory for all staff to attend annually. Prospective provider interview May 2019 – confirmed their commitment in meeting the requirements of the restraint minimisation standards.
Standard 2.2.1: Restraint approval and processes 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.	FA	The processes and agreements required for approval are clearly described and adhered to. Responsibility for restraint coordination is delegated to the restraint coordinator who is an RN. The decision to seek approval for the use of restraint is made by the restraint coordinator with input from care staff, the resident's GP, and the resident's family. Evidence of family involvement in the decision making was on file in each case. Use of a restraint is part of the plan of care, and this is signed off by the resident's Enduring Power of Attorney (EPOA) and GP. Review of residents' records and interviews with the coordinator showed that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored, analysed and reviewed. Approval for ongoing restraint needs is reviewed every three months or earlier if indicated.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The RN is the restraint coordinator. She undertakes the initial assessment with input from the resident's family, review of any incidents related to falls and input from care staff. The RN was able to describe the documented process. Evidence of family involvement was evident in the approval process and consent was given through signature on the restraint documentation. The GP of the resident is involved in the final decision on the safety of the use of the restraint. The GP also signs the restraint documentation. The assessment process identified the underlying cause, history of restraint

		use, cultural considerations, alternatives to restraint and associated risk. 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.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised and centred around a person-centred approach in consultation with family and medical services. The residents' records have signed copies of the individual assessment, restraint alternatives, informed consent signed by the resident's EPOA, GP sign off, and an individual restraint minimisation care plan when restraints are in use. Frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had all the necessary details and were complete. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. There have been no adverse events in response to restraint use within the service. 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 with sufficient information to provide an auditable record. 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. Most of the staff have completed dementia education, with four newer staff currently studying for the qualification. The manager is aware of the requirement to have all care staff complete the required education/training. Observation of a resident using a safe seat showed this was discreetly applied and regularly taken off to allow the resident movement. Interviews with families confirmed that they were consulted on matters pertaining to the resident and their care and there was clear documentation that this was taking place in the resident's documentation.

Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed frequently, during interRAI and care planning reviews, and as required in response to resident's changing needs. 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.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The use of restraint is constantly under review within the service with clear documentation showing regular evaluation. Internal audit of restraint use takes place three monthly. Policy was clear about how and when restraint would be used and family and medical consent sought. Six-monthly review of all restraint use is in place and includes all the requirements of this Standard. Individual use of restraint use is reported at staff meetings as confirmed in minutes and by staff interviewed. Monitoring of the residents while they were using the restraint was completed and appropriate to their individualised care plan. The manager and RN both attend bi-monthly restraint, infection control and certification meetings with other managers and registered nurses from within the Waikato DHB area.

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

No data to display

End of the report.