

Ativas Limited - Cairnfield House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Ativas Limited
Premises audited:	Cairnfield House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 July 2020 End date: 23 July 2020
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:	88

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
Yellow	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
Red	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

Cairfield House provides rest home and hospital level care for up to 89 residents. On the day of the audit there were 88 residents.

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

The service is managed by a facility manager (non-clinical), who is supported by a clinical manager (registered nurse). The residents, relatives and general practitioner interviewed spoke highly of the care and support provided.

Improvements are required to the quality programme around documentation of discussion of issues and resolution of actions or recommendations, and to restraint.

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.	Green	Standards applicable to this service fully attained.
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy, and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Residents and family reported that communication with management and staff is open and transparent. Complaints and concerns have been managed and a complaints register is maintained.

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.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality goals are documented for the service. The goals, indicators, policies and procedures are documented and reviewed. Key components of the quality management system are documented and include management of complaints, a documented internal audit schedule, completion of annual satisfaction surveys, incidents and accidents recorded, and a health and safety programme documented.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. There is always a registered nurse on duty. Ongoing training is provided and there is an implemented training plan. Rosters and interviews indicated that there are sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs.

Resident information is held securely and meets all requirements for health records management.

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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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses in the hospital and medication competent healthcare assistants in the rest home are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Residents commented positively on the 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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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All but three rooms are single. There are two rooms with ensuites, eighteen rooms share showers and toilets and there are sufficient communal showers and toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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There is a documented policy around restraint minimisation and use of enablers. The restraint coordinator maintains a register of any resident using a restraint or enabler. The service had three residents using a restraint and one using an enabler. Staff receive education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

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	47	0	3	0	0	0
Criteria	0	97	0	4	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>Information around the Code of Health and Disability Consumers' Rights (the Code) is provided to residents and their families. Policies relating to the Code are implemented. All interviewed, including two managers (one facility manager and one clinical manager); 12 care staff (eight healthcare assistants, one enrolled nurse, three registered nurses); two activities staff, one cook, one facility administrator, one laundry staff, one maintenance staff, confirmed their understanding of the Code and provided examples of how the Code is applied to residents' care. Staff receive training about the Code during their induction to the service. This training continues through the staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (five rest home including one respite, one Māori and one young person with a disability (YPD) and five hospital including one ACC respite, one long-term chronic health care (LTS-CHC) and one YPD). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the resident's record.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Advocacy brochures from the Health and Disability Advocacy Service are included in the information provided to new residents and their family during their entry to the service. Posters advertising advocacy services were sighted in Māori and English with these displayed in visible locations. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. Education is provided by the local advocate from the Nationwide advocacy service.</p> <p>Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.</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>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with friends and community groups. Interviews with all residents confirmed that they are encouraged to remain active in their community and participate in social activities external to the aged care facility. Local entertainers regularly visit the facility as sighted on the day of audit.</p> <p>Family interviewed stated that they could visit at any time and were always made to feel welcome.</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 procedure is provided to residents and families during entry to the service. Complaints forms are located at reception. A register of all complaints received is maintained. There have been five complaints received in 2020 (year to date). Documentation including follow-up letters and resolution demonstrated that complaints are well-managed.</p> <p>Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly. None of the family or residents interviewed had any complaints or concerns about the service but all thought that these would be addressed in a timely manner if raised.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information provided to new residents and their families. The facility manager</p>

<p>Consumers are informed of their rights.</p>		<p>and/or clinical manager discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly resident/family meetings. All eleven residents interviewed (eight rest home including one young person under 65 years and three hospital including one young person) and five family members (one rest home and four hospital) interviewed, reported that the residents' rights were being upheld by the service.</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>The residents' personal belongings are used to decorate their rooms. Privacy signage is on communal toilet doors.</p> <p>The care staff interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when care is being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All residents and families interviewed confirmed that the residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff attend mandatory education and training on abuse and neglect, which begins during their induction to the service. Links are in place with Age Concern for referral if abuse and/or neglect is suspected. Incidents reviewed for 2020 did not include any related to abuse or neglect. The general practitioner and external provider interviewed stated that there was no evidence of abuse.</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>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. Links are established with local kaumātua. Resident rooms are blessed following a death.</p> <p>Staff education on cultural awareness begins during their induction to the service and continues as a regular in-service. The healthcare assistants interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service. Two residents living at the facility who identified as Māori during the audit were interviewed and both stated that their cultural needs were assessed and strategies to support them put in place. One resident stated that they had grown up on a marae speaking only te reo Māori and stated that this service was like their marae. They confirmed that some staff spoke te reo Māori with them and that staff promoted their culture. Cultural values and beliefs that are identified are</p>

		<p>documented in the resident's care plan.</p> <p>The service has links with community providers and groups. Children from Otangarei School entertain residents and Ringa Atawhai Matauranga provides education for staff. Te Hau Awhiowhio O Otangarei Trust supports kuia and kaumātua to access care services.</p> <p>There are cultural safety and awareness meetings which focus on improving outcomes for Māori and people of other ethnicities. These meetings are expected to occur quarterly; however, these have been delayed in 2020 because of the lockdown in level four Covid-19.</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>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family, and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline.</p> <p>Beliefs and values are discussed and incorporated into the residents' care plans, as evidenced in care plans reviewed. Residents and family interviewed confirmed they were involved in the assessment and care planning process, which included the identification of individual values and beliefs.</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>Professional boundaries are discussed with each new employee during their induction to the service. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there are any specific issues raised.</p> <p>A review of incidents and complaints for 2020 did not identify any evidence of discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service meets the individualised needs of residents who have been assessed according to the level of care documented. The service has policies and procedures, and equipment to support implementation of rest home and hospital level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Integrated quality/management and staff meetings are conducted.</p>

		<p>The service receives support from the Northland District Health Board (NDHB) and local community hospice services. The external provider interviewed stated that their experiences with staff evidenced a high quality of care and willingness to learn.</p> <p>Residents, family, and the general practitioner interviewed spoke very positively about the care and support provided.</p> <p>Improvements since the last audit included extra hours allocated to interRAI and care planning documentation with improvements noted since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy. The policy also describes that open disclosure is part of everyday practice. The care staff and managers interviewed understood about open disclosure and providing appropriate information and resource material when required. Evidence of communication with family/whānau is recorded in the residents' progress notes.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Fifteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the Citizens Advice Bureau. Families and staff are utilised in the first instance and a number of staff also speak other languages.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The facility is owned by Ativas Limited and is managed by a facility manager. Cairnfield House can provide care for up to 89 residents at rest home and hospital (medical and geriatric) levels of care. There are 26 rest home beds, 20 hospital only beds and 43 dual-purpose beds (including two rooms able to cater for two residents in each). On the day of audit, there were 33 residents identified as requiring rest home level of care (including one resident using respite level of care, one resident identified as YPD and one resident under ACC contract) and 55 resident in hospital level of care (including one resident admitted under a LTS-CHC contract, two residents admitted under ACC contract, one resident using respite services).</p> <p>An annual plan has been developed in the past year that includes a philosophy, values, and measurable goals. Goals documented for 2020 have recently been completed having been delayed because of COVID-19 and the absence of the facility manager.</p> <p>The owner maintains an on-site office and is present most days. The facility manager is a</p>

		<p>registered diversional therapist who commenced employment at the facility 21 years ago as a healthcare assistant and has progressed through various roles since then. The facility manager was appointed to the role of facility manager in September 2013 and is supported by a clinical manager who is a registered nurse (RN) with a current practising certificate and experience in the aged residential care industry.</p> <p>Both managers have completed at least eight hours of training related to management of an aged care facility, relevant to their role and responsibilities.</p> <p>The facility manager had a period of leave earlier in 2020 with the clinical manager providing leadership for the organisation. The district health board noted that they had not been informed of the temporary absence of the facility manager formally however it was also noted that the clinical manager maintained verbal communication with the district health board.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the absence of the facility manager, the clinical manager assumes the facility manager's responsibilities. A senior registered nurse takes responsibility for clinical oversight when the clinical manager is on leave. The senior registered nurse interviewed was aware of their role.</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>	PA Low	<p>A quality and risk management programme is in place. Interviews with the facility manager, clinical manager, care staff and household staff reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>There are policies and procedures in place with these relevant to the service types offered. All have been reviewed as per schedule (ie, updated at least two yearly or sooner if there is a change in legislation, guidelines, or industry best practise).</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Quality improvement data is discussed at monthly staff meetings, and other relevant meetings such as quarterly infection control, health and safety meetings. Registered nurse meetings are expected to be held monthly, noting that the service did not hold these meetings as regularly while in COVID level four as staff were kept in work 'bubbles' to prevent cross infection as advised by public health services. The clinical manager acted as the key clinical conveyor of information during this time.</p>

		<p>Issues and recommendations are identified in meeting minutes, audits (completed as per the internal audit schedule) and surveys, however at times, corrective action plans are not documented and there is little evidence of resolution of issues in documentation reviewed.</p> <p>Residents and family are able to discuss issues and raise concerns through the monthly resident/family meetings and through annual surveys. The last survey was completed in April 2020 with a high level of satisfaction.</p> <p>Hazards are identified, managed, and documented on the hazard register. There is a designated health and safety officer. Health and safety issues are discussed at monthly quality/staff meetings with action plans documented to address issues raised. Health and safety meetings are also held quarterly. Falls prevention strategies include the use of sensor mats and implementing strategies for frequent fallers.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>An accidents and incidents reporting policy is in place. There was evidence to support actions are undertaken to minimise the number of incidents. Fifteen accident and incident forms were evaluated. Clinical evaluation of residents following an adverse event is conducted by a registered nurse with documentation including neurological observations completed for residents following an unwitnessed fall.</p> <p>Adverse events are linked to the quality and risk management programme. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events.</p> <p>The facility manager is aware of the requirement to notify relevant authorities in relation to essential notifications. One section 31 notification was documented following the death of a resident and a second section 31 notification for a resident who was discharged by the hospital to the resident's home as opposed to the service.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Ten staff files sampled (the facility nurse manager, four registered nurses, the activities coordinator, one cook, and three healthcare assistants), evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented</p>

		<p>competencies and induction checklists. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. There is an annual education plan being implemented that includes competencies that must be completed by staff.</p> <p>Twelve healthcare assistants have completed level two training; eight have completed level three training and fifteen have completed level four training. Eight of the sixteen registered nurses have completed interRAI training and one is in training.</p> <p>Residents stated that staff are knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the 88 residents. The clinical manager works Monday to Friday. In addition to the clinical manager there are two registered nurses rostered on a morning shift. On an afternoon shift, there are two registered nurses and one registered nurse on overnight.</p> <p>On an AM and PM shift there are eleven healthcare assistants rostered on for full shifts, one short shift on both mornings and afternoons and five rostered on nights. There is a house assistant on in the morning and afternoon shifts. Extra staff can be called on for increased resident requirements.</p> <p>Activities staff are rostered on five days a week. There are separate domestic staff who are responsible for cleaning and laundry services. A physiotherapist was able to be contracted to provide services, however that physiotherapist is no longer able to be contracted and the service is working to find an alternative contractor.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked storage facility located on the premises.</p> <p>Residents' files demonstrated service integration. Entries are legible, dated, timed, and signed by the carer, and include their designation.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the Aged related Residential Care (ARRC) contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</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>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were four residents self-administering on the day of audit. A consent form had been signed and the residents deemed competent to self-administer. The medications were in locked drawers. There are no standing orders. There are no vaccines stored on site</p> <p>The facility uses a paper-based and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer all medications in the hospital, but medication competent HCAs may administer medications in the rest home. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication fridge temperatures and medication room temperatures are checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for medications on medication signing sheets. Twenty medication charts were reviewed (ten hospital and ten rest home). Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</p> <p>The facility is currently in the process of moving to an electronic medication system.</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 service has two cooks who cover Monday to Sunday and one kitchen assistant in the morning and one in the afternoon. All cooks have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served in each area from bain maries. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance.</p> <p>Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The six weekly menu cycle is approved by a dietitian. All resident/families interviewed were satisfied with the meals. Many commented on the home baking.</p> <p>The food control plan was verified on 18 February 2020.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall, the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) falls and pressure injury risk.</p>
<p>Standard 1.3.5: Planning</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>care plans are resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, district nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</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>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are taken when there is a head injury or for an unwitnessed fall.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently six wounds being treated. There is currently one superficial pressure injury.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</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>There is one diversional therapist who works 35 hours a week and one activities coordinator who works 36.5 hours a week. Both work across all areas. On the day of audit residents were observed listening to an entertainer, participating in happy hour, having morning talks, being read to, playing bingo and having one-on-one sessions. One resident had been to a hydrotherapy session.</p> <p>There is a weekly programme on a whiteboard at reception. Weekly programmes in large print are also on noticeboards in all areas. Some residents like a copy of the weekly programme to keep in their room. The activities for aged care residents are in red and YPD activities are in green. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, bingo, news from the paper, music, quizzes, and</p>

		<p>games.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need.</p> <p>There is a weekly Roman Catholic and Anglican Communion. There are regular interdenominational prayer meetings.</p> <p>There are van outings twice weekly. Celebrations such as birthdays, Easter, Mothers' Day, Anzac Day, and the Melbourne Cup are held. The facility is currently celebrating Matariki and has a hangi planned. There are regular entertainers, especially on a Sunday.</p> <p>The facility has three birds and goldfish. Staff bring in their pet dogs to visit. They have pet therapy but this has not yet recommenced post Covid.</p> <p>There is community input from the local preschools, kapa haka groups and the RSA. Residents go out to stroke club, Forget Me Not, shops and cafés. YPD residents are encouraged to join in community activities. There are also life coaches and technology coaches available to them. The activities team ensure they have access to modern music and movies as well.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Except for the new admission, all plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP, and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation</p>

<p>External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>is maintained on resident files. There was evidence of where residents had been referred to the district nurse, hospice, and mental health services for older people. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</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>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturers' labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and face shields are available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 23 June 2021. There is a maintenance person who works full time five days a week. There is an assistant maintenance man who works three days a week. There is a contracted gardener. Contracted plumbers and electricians are available when required.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. Most areas are carpeted but the old wing and eight bedrooms still have vinyl. In the new wings, corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. In the old wing, corridors are narrower but still safe. Residents were observed moving freely around all areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>HCA's interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to</p>	<p>FA</p>	<p>Two rooms have ensuites. Eighteen rooms share showers and toilets. Every room has a hand basin. There are sufficient communal showers and toilets. Fixtures, fittings, and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are signs on all shower/toilet doors.</p>

personal hygiene requirements or receiving assistance with personal hygiene requirements.		
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	There are currently two rooms that have married couples sharing. Room dividers are available if required. All other rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
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	There are large and small lounges. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. The dining rooms are spacious. There is a hairdressing salon.
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	All laundry is done on site. There is a fulltime laundry coordinator who has a part time assistant and weekend workers. The laundry is divided into a dirty and clean area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away. All chemicals on the cleaner's trolley were labelled. There are two sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are kept closed when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an approved evacuation scheme. Evacuation drills occur at least six monthly with the results of these documented. All staff have completed education on emergency management. There is a staff member on duty 24/7 with a current first aid certificate. In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare batteries for lights, a gas barbecue, linen, continence products, torches and batteries, water, and blankets. Food dry stock and frozen food are available to support residents for at least three days. There is sufficient drinking water on site to support the maximum number of residents on site for at least three days.

		An electric call bell system is in use with residents stating that staff answer bells promptly. Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately.
<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	All bedrooms and communal areas have ample natural light and ventilation. There is a mixture of heat pumps, panel heaters and gas central heating. Staff and residents interviewed stated that this is effective. There is one outdoor deck area where residents smoke. All other areas are smoke free.
<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>There are clear policies and procedures for infection, prevention and control which minimises any risk of infection to residents, staff and visitors. Infection control management is appropriate to the size and scope of the facility. There is an infection, prevention and control coordinator. The coordinator liaises with and reports to the clinical manager. The responsibility for infection control is described in the job description. The coordinator collates monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator and the clinical manager.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks. During Covid 19 lockdown all appropriate measures were in place.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The IC coordinator is a very experienced RN. She has access to infection control expertise within the DHB, district nurse, public health, and laboratory. The GP monitors the use of antibiotics.
<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</p>	FA	The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies were developed

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.		by a consultant.
<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>The IC coordinator and an appointed educator are responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have participated in IC education in the last year and there is more training planned for 2020. Resident education occurs as part of providing daily cares and as applicable at resident meetings. During Covid 19 lockdown there was a communication system in place to ensure staff were made aware of any changes.</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>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and staff stated this is analysed monthly to identify areas for improvement or corrective action requirements. However, there is very little documented evidence of discussion, actions or resolution of issues (link 1.2.3.6).</p> <p>Infection control internal audits have been completed. Infection rates have generally been low. Definitions of infections are in place appropriate to the complexity of service provided. Systems are in place that are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers and restraint procedures. The education and training programme includes regular in-service training on restraint minimisation. Interviews with the care staff confirmed their understanding of restraints and enablers. The service was restraint-free until this year. While the philosophy remains in place, the aim is to also meet resident individual needs.</p> <p>Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had one resident using an enabler and three hospital level residents using a bedrail as a restraint. Written consent was provided by the resident for the use of their enabler (bedrail).</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The facility maintains a process for determining approval of all types of restraints used. The restraint coordinator completes a restraint assessment, which is then discussed with the general practitioner and family prior to commencement of any restraints. The restraint committee is defined in the restraint minimisation and safety policies and procedures.</p> <p>The duration of each restraint is documented in the restraint plans of residents. Healthcare assistants who are overseen by the registered nurse are responsible for monitoring and completing restraint forms when the restraints are in use.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>PA Low</p>	<p>The assessment process includes reference to the use of restraint. Restraint assessments should include risks related to the use of the restraint and any assessment of the resident in relation to underlying causes for the behaviour or condition, any existing advance directives, whether the resident has been restrained in the past, any history of trauma or abuse, if the restraint will be culturally safe, how restraint use will be ended and possible alternatives. One of the two files reviewed where restraint was in use included an assessment that showed that restraint had been identified as a need. Neither file included documentation of any risks related to the use of the identified restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Low</p>	<p>Before resorting to the use of restraint, the restraint coordinator utilises other means to prevent the resident from incurring injury, for example, the use of sensor mats. Consent for the use of restraint is signed by the general practitioner, family, and the restraint coordinator. Restraints are beginning to be incorporated in the long-term care plans and reviewed at least six monthly. The restraint register is up to date.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint is still required. The family are involved in the evaluation of the restraint's effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. The policy describes how restraint minimisation and safe practices are reviewed.</p> <p>The service has not yet had to review current use of restraint, however the clinical manager (restraint coordinator) was able to describe how this would occur.</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>	<p>FA</p>	<p>The facility demonstrates the monitoring and quality review of their use of restraints through the restraint coordinator interview and through documentation of the policy. The audit schedule was sighted and includes an audit of restraint reviews. There are corrective actions put in place when issues are identified.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>The service captures quality data (falls, skin tears, medication errors, infections, accident and incident and compliments/complaints). Where areas requiring improvements were noted, corrective action plans were not consistently documented, reviewed, or signed out once completed.</p>	<p>Where quality data collected indicated areas requiring improvements (examples include infections, falls, lacerations, fire safety and resident care plans), corrective action plans were not consistently documented. Where actions are documented they have not consistently been reviewed and</p>	<p>Ensure that all corrective action plans are documented, reviewed, and signed out once completed.</p> <p>90 days</p>

			signed out once completed.	
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>	PA Low	One of the two files reviewed included documentation of an assessment. The assessment documented did not include reference to all criteria identified in 2.2.2.1. Neither resident record included reference to risks associated with the use of the restraint.	One of the two files reviewed did not include documentation of an assessment and neither file reviewed included an assessment of the risks related to the use of bedrails used as a restraint.	<p>Document a comprehensive assessment for any resident using restraint and include an assessment of any risks related to the use of the restraint.</p> <p>90 days</p>
<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p> <p>(d) When the environment is appropriate and safe for successful initiation;</p> <p>(e) When adequate resources are assembled to ensure safe initiation.</p>	PA Low	One of the two files reviewed where restraint was used had documentation in the long-term care plan that provided interventions and reasons for the restraint.	One of the two files reviewed where restraint was used did not have strategies or interventions detailed in the long-term care plan.	<p>Ensure that the long-term care plan documents strategies and interventions relevant to the assessment.</p> <p>90 days</p>

<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	<p>PA Low</p>	<p>The restraint records in two files did not include reference to all criteria identified in 2.2.3.4 a) to g). One of the two files reviewed where restraint was used included documentation of the frequency of monitoring of restraint when this was in use. Monitoring of restraint when in use was recorded for both residents reviewed, however monitoring of the restraint when in use was not as per the frequency of monitoring of restraint recorded in the care plan for one resident.</p>	<p>The two records reviewed did not include documentation in sufficient detail to provide an accurate account of the indication for use, intervention, duration, and its outcome as per 2.2.3.4.</p> <p>One of the two files reviewed where restraint was used did not include documentation of the frequency of monitoring of restraint when this was in use.</p> <p>Monitoring of the restraint for one resident was not as per that documented in the long-term care plan.</p>	<p>Ensure that documentation for any resident using restraint is completed in sufficient detail to provide an accurate account of the indication for use, intervention, duration, and its outcome as per 2.2.3.4.</p> <p>Ensure that monitoring requirements are documented in the long-term care plan with these updated as changes occur.</p> <p>90 days</p>
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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.