

Aldwins House Limited - Aldwins 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 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:	Aldwins House Limited
Premises audited:	Aldwins House Residential Care Centre
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 October 2021 End date: 8 October 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	39

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Aldwins House can provide rest home and hospital level care for up to 145 residents.

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

The residents and family members spoke positively about the care provided.

There were no areas requiring improvement identified as part of this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Aldwins House when they are admitted. This is displayed throughout the facility in both English and te reo Maori. Opportunities are provided to discuss the Code, consent, and availability of advocacy services at the time of admission and thereafter as required.

Services at Aldwins House are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for any residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.


There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

Aldwins House has linkages to a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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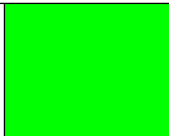
Promisia Health and Care Limited is the governing body and is responsible for the services provided at this facility. The mission, vision, and values of the organisation are documented and communicated to all concerned. There are systems in place for monitoring the services provided, including regular reporting to the general manager group facilities.

The general manager group facilities and a care manager have secondment positions, to ensure the facility is managed until two new appointees start in the respective positions. Both are registered nurses with aged care experience and have been in these positions since July 2021.

There is an internal audit and quality programme. Risks are identified, and a hazard register is in place. Adverse events are documented on an electronic accident/incident form. Facility meetings are held where there is reporting on various clinical indicators, quality and risk issues, and discussion on identified trends. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resources management. A mandatory education programme is provided for staff. There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with liaison evident between the Needs Assessment Service Co-ordinator (NASC) and the clinical team. Relevant information is provided to the potential resident and their family to facilitate admission to the facility.

The residents' needs are assessed by the multidisciplinary team on admission and within the required time frames. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. The

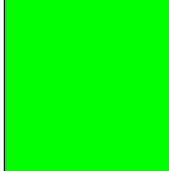
residents' files reviewed showed that the care provided, and the needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health providers as required. Shift handovers and communication sheets promote continuity of care between each of the shifts.

The planned activity programme is delivered by one part time diversional therapist. The programme provides the residents with a variety of individual and group activities and maintains their links with the community. There is currently no facility vehicle available for outings.

Medicines are managed according to the policies and procedures which are based on current best practice and consistently implemented. Medications are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with any special requirements catered for. Policies guide the food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with the meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building had a current building warrant of fitness displayed.


There is a reactive and preventative maintenance programme, including equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of suitable materials for this environment.

Residents' bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids, and to allow for care to be provided. Lounges, dining areas, and sitting alcoves are available for residents and their visitors. External areas and gardens are safe for residents to mobilise around.

A call bell system is available to allow residents to access help when needed. Security systems are in place with regular fire drills completed.

Protective equipment and clothing are provided and used by staff. Chemicals are safely stored. The laundry service is conducted on-site, by designated laundry personal. Cleaning of the facility is conducted by household staff and monitored for effectiveness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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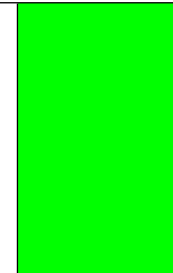
Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the clinical manager who is a registered nurse.

On the day of the on-site audit, there were no restraints in use. Seven enablers were in use. Restraint is only used as a last resort when all other options have been explored.

Staff receive education relating to the use of and management of restraints and enablers.

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 prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed if required.

Staff demonstrated good knowledge around the principals and practice of infection control, guided by relevant policies and supported with regular education.

Age care specific infection surveillance is undertaken, with data analysed, benchmarked and results reported through to all levels of the organisation. Follow up action is taken as and when required.

Covid-19 related processes are in place to manage change in Ministry of Health Covid-19 response levels.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Aldwins House has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The Code is displayed throughout the facility in both English and te reo Māori, residents receive a copy of this in the admission pack. 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 part of the ongoing study days for all staff as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principals and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent (historically) had not been gained appropriately on admission. Consent relating to photos, outings, for example, had not been completed using the organisation's standard consent form. This had come to the attention of the acting clinical manager (CM) and general manager (GM) through the internal audit process. Management have developed a corrective action plan to ensure full compliance and are currently working towards this.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents is defined and documented, as relevant, in the resident's record. Staff</p>

		<p>demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed gaining consent for day-to-day care on an ongoing basis.</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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the service are on display and available throughout the facility in both English and te reo Māori. Family members and residents spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff are also aware of how to access the Advocacy Service if this is required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities and entertainment as COVID-19 allows. The facility encourages visits from family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff. During COVID-19 visitors and families book into visit their relatives and loved ones and are screened appropriately as they enter the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Policies and procedures relating to complaints management are compliant with Right 10 of the Code. Systems are in place that ensure residents, and their families are advised on admission to the facility of the complaint process and the Code. The complaints forms are displayed and accessible within the facility. Staff interviewed confirmed their awareness of the complaints processes. Residents and families demonstrated an understanding and awareness of these processes.</p> <p>The general manager (GM) is responsible for complaints management. A complaints register is maintained. The register noted four complaints in 2021; three are closed. One complaint was recorded related to a verbal complaint received by the district health board (DHB). This was a verbal anonymous, complaint related to staffing and stock. An investigation was completed. This resulted in changes to the stock inventory to ensure it aligned with the residents' care plans.</p> <p>The open complaint was received on 2 October 2021 and relates to three issues, staffing, laundry, and maintenance. The GM responded on 4 October 2021, and an investigation process commenced. This was sighted at audit.</p>

		There were no other complaints currently with any other external agencies.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	When interviewed, the residents and family/whanau of Aldwins House, 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 from discussion with staff. The Code is displayed in English and te reo Māori at the reception and throughout the facility and each resident has a copy of this in the admission folder. Information on how to make a complaint and provide feedback is available and displayed in reception along with the complaints policy and information on how to contact the Advocacy Service.
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 and their families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff understand the need to maintain privacy and were observed doing so throughout the audit when attending to the personal cares of residents, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families. All residents have a private room and ensuite facilities. There is a large lounge communal area available downstairs with quiet corners to have private conversations. Residents are encouraged to maintain their independence by participating in activities within the facility and outside in the community as COVID-19 restrictions allow. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs have 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 be occurring during the orientation period 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	FA	There is currently one resident at Aldwins House that identifies as Māori. A pepeha was completed as part of the admission process. Staff receive annual education to enable them to support residents who do identify as Māori to integrate their cultural values and beliefs. The principals of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whanau. There is a current Māori health plan and guidance on tikanga best practice is available and there

a manner that respects and acknowledges their individual and cultural, values and beliefs.		are staff who identify as Māori in the facility able to act as a resource.
<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	Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Staff can access an external interpreter service for residents if required and several staff members are bi-lingual. Residents' personal preferences required interventions and special needs were included in all care plans that were reviewed. For example, likes and dislikes and attention to preferences around activities of daily living.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Residents and family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. The facility general practitioner also expressed satisfaction with the standard of services provided to the residents with reference to the 'acting clinical manager and general manager' and the changes they have introduced. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. 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.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service provides and encourages good practice, this is demonstrated through evidence-based policies, input from external specialist services and allied health professionals, for example clinical nurse specialists, wound care specialists, dieticians, podiatrist and education for staff. The GP confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported that they receive management support for external education and access their own professional networks. Ongoing yearly training for RNs and care staff is provided both in house and with external providers as COVID-19 allows.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	Residents and family members stated they were kept well informed about any changes to their own or their relative's status, they are advised in a timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the residents' records that were reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principals of open disclosure, which is supported by

communication.		policies and procedures that meet the requirements of the Code. Staff know how to access an interpreter should this be required, and several staff are bi-lingual.
<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>Aldwins House (Aldwins) is part of the Promisia Health and Care Limited (Promisia). The Promisia management team provide support to the facility with the general manager group facilities (GM) and another facility clinical manager (CM) who were on secondment during this on-site audit. The GM discussed the process once a facility manager is employed, this included a weekly work planner, that includes a report on the key performance indicators (KPI) and a monthly synopsis. The monthly synopsis is reported through to the Promisia board.</p> <p>Promisia has an overarching business plan, and Aldwins has a business plan specific to the facility. Posters observed at the entrance of the facility and information booklets are available for residents, staff, and family and include the organisation's mission statement, values, and goals.</p> <p>Issues were identified during onsite visits and reports received by the GM that KPI targets were not being met by the previous management team. The decision was taken at the board level after the resignations of the previous management team, to place the GM and another facility clinical manager as secondment management, until a new management team could be appointed. Both the GM and CM are registered nurses (RNs) with extensive aged care facility experience and have been on site since July 2021. The position of the new facility manager (FM) and care manager (CM) has been confirmed. The new FM and CM starting on 26 October 2021. An orientation programme has been developed and includes onsite support by the secondment team. The required section 31 notifications had been completed and were sighted at audit, and the DHB was notified at the time of the changes.</p> <p>The facility can provide care for up to 145 residents, with 39 beds occupied on the day of the audit. This included:</p> <ul style="list-style-type: none"> - 23 residents requiring rest home level care, with one under 65 years of age under a physical long-term care contract. - 16 residents requiring hospital-level care, with two under 65 years of age under a physical long-term care contract. <p>There is a planned approach to increase the occupancy. The facility is over two levels with the upper level refurbished to provide care, but not currently utilised.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The GM discussed the future on-call arrangements. During any absence of the facility manager, the care manager will carry out all the required duties under delegated authority. For any extended period of leave, such as the present circumstances, the Promisia management team will provide support and cover. A senior registered nurse (RN) has been appointed to provide oversight of clinical care when required. As the facility residents' numbers increase, additional RNs will be appointed.</p> <p>Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Aldwins uses the quality and risk management system provided by an external contractor, that reflects the principles of continuous quality improvement.</p> <p>The external contractor reviews all policies and personalises these to the facility. Policies reviewed covered the necessary aspects of the service and contractual requirements, including reference to the interRAI long-term care facility (LTCF) assessment tool and process. Policies included references to current best practice and legislative requirements. New and revised policies are introduced to staff at meetings and policy updates are also presented as part of relevant in-service education. Staff interviewed confirmed that they are alerted to new and revised policies and receive opportunities to read and understand the policies.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, key performance indicators, and implementation of an audit programme. Clinical indicators are collated monthly and benchmarked against other Promisia facilities by the GM. The GM reports monthly to the Promisia board.</p> <p>The internal audit programme is documented and implemented as scheduled. Internal audits cover all aspects of the service and are completed by the CM. Audit data is collected, collated, and analysed at the facility. Results are reported weekly to the GM and collated monthly for reporting to the board. The GM reported audit results prior to the current secondment positions noted significant issues with noncompliance to routine systems and processes. All audits were completed respectively by the CM to monitor compliance and identify gaps in service.</p> <p>An example noted at audit related to the admission checklist, which included the completion of all residents' consent, such as photos and outings. June 2021 noted significant noncompliance. The GM and CM developed an action plan, July 2021, another audit was completed, and not increased and again in August 2021, both audits noted a significant increase in compliance. October 2021 the CM reported at audit, that work towards full compliance continues. This was not identified as a corrective action plan at audit, as an action plan was in progress and the CM was ensuring all</p>

		<p>consents were completed.</p> <p>Interviewed staff reported that they are kept informed of audit activities and results at staff meetings.</p> <p>Satisfaction surveys for residents and families have not been completed as the facility has been open for less than 12 months. The GM confirmed the first satisfaction survey is planned for the end of the month. Residents' families interviewed reported being happy with the service including, communication, meals and the laundry service.</p> <p>Facility meetings are conducted, for example, general staff, head of department and RN meetings, and residents' meetings. Minutes of meetings evidenced communication with staff around aspects of quality improvement and risk management.</p> <p>Aldwins has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There was evidence of hazard identification forms completed when a hazard was identified. The GM is responsible for maintaining the hazard register and is currently the health and safety officer and has received appropriate training. A new officer will be appointed once the new FM starts in the position.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff understood the adverse event reporting process and were able to describe the importance of recording near misses. Staff are documenting adverse, unplanned, or untoward events in the electronic accident/incident management system. Electronic incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. Accident and incident forms are reviewed by the care manager and signed off when completed. The RNs undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>Policy and procedures comply with essential notification reporting, for example, health and safety, human resources, and infection control. The GM is aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility, unexpected deaths, sentinel events, notification of pressure injuries, infectious disease outbreaks, and changes in key clinical managers.</p> <p>Four section 31's notifications have been completed to notify authorities of the secondment of the GM, CM, resident admitted under the incorrect level of care, and a trespasser on the premises, with other relevant authorities notified.</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>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. A sample of staff records reviewed confirmed the organisation's policies are consistently implemented and records are maintained.</p> <p>Professional qualifications are validated. There are systems in place to ensure that annual practising certificates are current. Current certificates were evidenced in reviewed records for all staff and contractors that required them.</p> <p>Staff orientation documentation sighted included necessary components to the role. Health care assistants (HCAs) interviewed identified they are paired with a senior HCA until they demonstrate competency on specific tasks, such as hand hygiene or moving and handling. Staff interviewed reported that the orientation process prepared them for their role. Staff records reviewed showed consistent documentation of completed staff orientation.</p> <p>The organisation has a documented mandatory annual education and training module/schedule. The mandatory study days of continuing education include infection control, restraint/enabler use, moving, and handling. There are systems and processes in place to remind staff of the required mandatory modules and competencies training dates. Interviews confirmed that all staff undertake relevant education each year. Staff education records evidenced the ongoing training and education completed.</p> <p>Three RNs were identified as interRAI competent. The enrolled nurse (EN) is enrolled to start interRAI training.</p> <p>Performance reviews had not been undertaken as no staff member had been employed for over 12 months. Three monthly reviews are undertaken for all RNs and these were sighted in staff files reviewed.</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>Staffing levels meet contractual requirements. A senior RN is on call after hours and on the weekends. Adequate on-site RN cover is provided 24 hours a day, seven days a week. Registered nurses work 12-hour shifts on the weekends to cover contractual requirements, with agency staff utilised when required. The GM discussed the advertisement for RNs, and the difficulty of finding suitable applicants. Once additional RNs have been employed, there will be a reduction of the 12-hour shifts. Registered nurses are supported by an enrolled nurse and sufficient HCAs.</p> <p>There is a documented rationale in place for determining service provider levels and skill mix to provide safe service delivery. Rosters are completed on an electronic system and overseen by the GM and CM. Rosters sighted reflected that staffing levels meet residents' acuity and bed occupancy.</p>

		<p>Residents and families reported that staff provided them with adequate care. Health care assistants (HCA) reported there were adequate staff available and that they can manage their work.</p> <p>All RNs and the EN have a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. 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 stamped beside the entry.</p> <p>Archived records are held securely on site for 12 months and are readily retrievable. They are held for the required period before being destroyed. No personal or private resident information was on display during the audit.</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>Residents are admitted to Aldwins House following assessment from the Needs Assessment Service Co-ordinator (NASC), as requiring the level of care that Aldwins House provides. Prospective residents and their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. All residents are admitted to the facility in accordance with current MOH, COVID-19 guidelines.</p> <p>Family members interviewed stated that they were happy with the admission process and the information that had been provided to them. Files reviewed contained the completed demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner. The service uses the DHB 'Yellow Envelope' system to facilitate the transfer of residents to and from acute care settings. There is open communication between all services, the residents, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, is provided for ongoing management of the resident. All referrals are documented in the progress notes.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The Medication Management Policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The medications are checked against the prescription and signed in electronically by the RN's. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. 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 and six-monthly stock checks and accurate entries with controlled drugs signed in. All registered nurses are competent with syringe drivers.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of temperature records taken.</p> <p>Good prescribing practices were noted. These included 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 was consistently recorded on the medicine chart. There are no standing orders or verbal orders. Vaccines are not stored on site. Residents and staff have received the required COVID-19 vaccines except for those who did not want to be vaccinated. For new admissions into the facility, if they are not vaccinated and wish to be, they are taken to a local provider for their COVID-19 vaccination.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site with a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietician.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries. At the time of the audit, the kitchen was observed to be clean. The cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored and recorded as part of the plan using a paper-based recording system.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary</p>

		<p>profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by residents and families/whānau that were interviewed. There are sandwiches and snacks available 24 hours a day for residents should they be hungry between meals. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received, but the resident does not meet the entry criteria, there are no vacancies, or the referral has been declined from the facility due to inappropriate referral from the NASC service, there are policies and procedures in place to ensure that the prospective resident and family are supported to find an appropriate level of care. At the time of the audit, they have not declined a resident.</p> <p>If the needs of the resident change and they are no longer suitable for the services offered a referral for reassessment is made to the NASC and a new placement would be found in consultation with the resident and the whanau/family.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission to Aldwins House, residents are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, cognition and behaviour, nutrition and activities, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents (except for respite, ACC and YPD residents) are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require.</p> <p>Those long-term residents not being assessed using the interRAI assessment tool have clinical assessments to inform care planning. These are reviewed every six months or if the resident's needs change.</p> <p>Interviews, documentation, and observation verified the RNs were familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs.</p> <p>All residents have current interRAI assessments completed by one of the trained interRAI</p>

		assessors on site. InterRAI assessments are used to inform the care plan.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans at Aldwins House are electronic. When reviewed they reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly documented, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and family/whanau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The GP interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the GP should a resident's condition change. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources were available and suited to the levels of care provided and in accordance with the residents' needs.</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>	FA	<p>The activities programme is provided by one part time qualified diversional therapist, who supports the residents Monday to Friday 10.00am till 3.00pm. Puzzles, movies and activities are left out at the weekends for residents to engage with, overseen by care staff.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated monthly to ascertain resident's likes and dislikes. This is documented in the progress notes, all of which forms part of the six-month multidisciplinary care plan review.</p> <p>There is one resident who identifies as Māori and support is given for activities culturally appropriate for them. It is the aim of the diversional therapist to get the residents engaging in the community as much as COVID-19 restrictions allow. There is currently no facility van available, but</p>

		<p>a regular walking group gets residents out.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'bingo', knitting and crafts. Plans are in place for visiting entertainers as COVID-19 allows. There is individual, group and gender specific activities for female and male residents. Hospital and rest home residents have the same activity programme. There is a large activity room and lounge for residents to use, as well as the individual's bedrooms where they can watch their own television or listen to the radio. The Activities Calendar is on display and each resident is given a copy of the monthly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular basis.</p> <p>Residents and families can evaluate the programme through day-to-day discussions with the activities co-ordinator, residents interviewed confirmed the programme was interesting and varied.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated each shift and reported on 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/clinical reassessment or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans are consistently reviewed for infections, pain and weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in the residents' files to the occupational therapy and continence nurse. The resident and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as ringing an ambulance if the situation dictates.</p>
<p>Standard 1.4.1: Management Of</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous</p>

<p>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>substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant staff training. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>Protective clothing and equipment appropriate to the risks associated with waste or hazardous substances being handled are provided and were being used by 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>A current building of fitness was displayed.</p> <p>There is a preventive and reactive maintenance programme in place. Staff were aware of the processes of reactive maintenance requests to ensure timely repairs are conducted. This was confirmed at the management interview. The facility does not currently have a maintenance staff member and is currently supported by a casual maintenance contractor.</p> <p>Visual observation evidenced the facility and equipment are maintained to an adequate standard. This was confirmed in documentation reviewed and staff interviews.</p> <p>Staff and residents confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment.</p> <p>The external areas are safely maintained and appropriate to the resident groups and setting. Residents are protected from risks associated with being outside. The gardens maintenance is contracted out and these were well maintained.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Bedrooms on the lower level of the facility have full ensuites. Five rooms on the upper level have a handbasin and will require sharing of bathroom facilities. The shared bathroom is currently being renovated, to ensure it is an appropriate design for residents.</p> <p>Separate toilets are available for staff and visitors.</p> <p>The fixtures, fittings, floors, and wall surfaces are constructed from materials that can be easily cleaned. Toilets and showers have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote residents' independence.</p> <p>Hot water temperatures are monitored monthly. When there have been hot water temperatures above the recommended safe temperature, action is taken, and rechecking of the temperature</p>

		occurs to ensure it is maintained at a safe temperature.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms are designated dual-purpose and provide single accommodation.</p> <p>Rooms are personalised with furnishings, photos, and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs, and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff.</p> <p>Residents can access areas for privacy, if required. Residents were observed moving freely within these areas.</p> <p>Residents confirmed there are alternative areas available to them if communal activities are being run in one of these areas and they do not wish to participate in them.</p> <p>All the furniture has been purchased as part of the refurbishment of the facility and is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry policies and procedures are available.</p> <p>Laundry is undertaken on-site in a dedicated laundry and the dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow, and handling of soiled linen. There is a dirty-to-clean flow provided in the laundry. The household staff member described the management of the laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to other residents. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>The household member also described the cleaning process and the use of chemicals for cleaning purposes. There are safe and secure storage areas for cleaning equipment and chemicals and staff have access to these areas as required.</p> <p>Sluice rooms are available for the disposal of soiled water/waste.</p> <p>Handwashing facilities are available throughout the facility with alcohol gels in various locations.</p>

		The effectiveness of the cleaning and laundry services is audited via the internal audit programme.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Documented systems are in place for essential, emergency, and security services. The fire evacuation scheme for the facility has been approved by the New Zealand Fire Services. The fire evacuations are conducted six-monthly. The last fire drill was conducted in May 2021. The staff training register provided evidence that all staff have completed first aid training and fire evacuation education.</p> <p>There is emergency lighting, gas for cooking, emergency water supply, and blankets in case of emergency. Emergency equipment accessibility, storage, and stock availability is to a level appropriate to the service setting requirements.</p> <p>The pager call bell system in place is used by the residents, and/or staff and family to summon assistance if required and is appropriate to the resident groups and settings. Call bells are accessible, within reach, and are available in resident areas.</p> <p>Staff interviews confirmed security systems including internal security cameras are in place. Staff and families confirmed awareness of security processes. A poster at the main entrance alerts all visitors that security cameras are in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents are provided with adequate natural light and safe ventilation. Wall heating is available throughout the facility. Wall heaters are used in each resident's bedroom to allow residents to control the temperature in their own space.</p> <p>Residents and families confirmed the facility is maintained at a safe and comfortable temperature.</p> <p>An area outside the building is available for both residents and staff who smoke.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Aldwins House implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. A comprehensive and current infection control manual is available to staff and managers. There is evidence that formal reviews of the programme are completed annually.</p> <p>The acting clinical manager is the designated infection prevention and control co-ordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and reviewed at the monthly quality committee meetings. Infection prevention and control matters are also discussed at registered nurse meetings, staff shift</p>

		<p>handovers, staff meetings and ultimately at management meetings.</p> <p>Signage at the main entrance to the facility is relevant to the current COVID-19 alert levels and 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 and confirmed this had been further reinforced since the COVID-19 pandemic emerged with a documented process for each of the alert levels.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control coordinator have the appropriate skills, knowledge and qualifications for the role. Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the GP and the public health unit, as required. The co-ordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>There is a COVID-19 management plan in place which details all the actions required by the service in response to each of the alert levels. The infection prevention and control coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing and clearly documented on each policy is the next review date. 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, as was appropriate to the setting. Hand washing and sanitiser dispensers are distributed around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and</p>	FA	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and in ongoing education sessions. Education is provided by suitably qualified RNs and the infection prevention and control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of</p>

consumers.		attendance is maintained.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The infection prevention and control coordinator reviews all reported infections and these are documented. New infections and any required management plans are discussed at shift handover, to ensure early intervention occurs.</p> <p>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 at staff meetings and during shift handovers. A good supply of personal protective equipment was available, and the facility has processes in place to manage the risks imposed by COVID-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The CM is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. The CM was familiar with the restraint policies and procedures.</p> <p>The facility has been restraint-free since August 2021, when the one resident that required restraint died. A similar process to that used for any restraint is used for use of enablers. Enabler use is documented and used voluntarily at the resident's request. Enablers use includes:</p> <ul style="list-style-type: none"> - bedrails, with three residents using a split bedrail to enable movement. - seat belts, with four residents requiring seat belts when in wheelchairs related to their muscular issues and to maintain their personal safety. <p>It is noted three of the residents require the use of bedrails and seat belts.</p> <p>The CM explained restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of minimisation. Regular training occurs and review of restraint and enabler use is completed and discussed at all quality and staff meetings.</p> <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The CM is the</p>

		<p>restraint coordinator and provides support and oversight for enabler and restraint management in the facility. The CM was familiar with the restraint policies and procedures.</p> <p>The facility has been restraint-free since August 2021, when the one resident that required restraint died. A similar process to that used for any restraint is used for use of enablers. Enabler use is documented and used voluntarily at the resident's request. Enablers use includes:</p> <ul style="list-style-type: none"> - bedrails, with three residents using a split bedrail to enable movement. - seat belts, with four residents requiring seat belts when in wheelchairs related to their muscular issues and to maintain their personal safety. <p>It is noted three of the residents require the use of bedrails and seat belts.</p> <p>The CM explained restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of minimisation. Regular training occurs and review of restraint and enabler use is completed and discussed at all quality and staff meetings.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.