

The Ultimate Care Group Limited - Ultimate Care Ranburn

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:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Ranburn
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 18 May 2016 End date: 19 May 2016
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:	53

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

Ultimate Care Ranburn provides residential care for up to 71 residents who require hospital, rest home and rest home dementia level care. The facility is operated by The Ultimate Care Group Limited.

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

This audit has resulted in a continuous improvement rating relating to the environment in the dementia unit, and identified that improvements are required around corrective action timeframes and restraint monitoring documentation.

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

There are three residents whom identify as Maori residing at the service at the time of audit. There are no known barriers to residents accessing the service. Services are planned to respect the individual care required, culture, values and beliefs of all the residents as individuals and as a collective.

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

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

The organisation respects and supports the right of the resident to make a complaint. The service has a complaints register and the information is recorded to meet the requirements of the standard. There were no outstanding complaints at the time of audit.

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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The Ultimate Care Group Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at Ultimate Care Ranburn and includes a documented scope, direction, goals, values, and a mission statement. Systems are in place for monitoring the service, including regular reporting by the facility manager to the head office.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by a clinical services manager/registered nurse. The clinical services manager is responsible for oversight of the clinical service in the facility.

There is an internal audit programme. Adverse events are documented on accident/incident forms. Corrective action plans are being developed, implemented, monitored and signed off. Various meetings are held and there is reporting of clinical indicators, quality and risk issues and discussion of any trends. Graphs of clinical indicators, including benchmarking are available for staff to view along with meeting minutes. Risks are identified.

There are policies and procedures on human resources management and human resource processes are followed. There are current annual practising certificates for health professionals who require them. An in-service education programme is provided for staff and attendance sheets are held on file. Staff are also encouraged to complete the New Zealand Qualifications Authority Unit Standards. Individual education records are maintained on staff files.

There is a documented rationale for determining staffing levels and the skill mix in order to provide safe service delivery that is based on best practice. The facility manager and clinical services manager are rostered on call after hours. Care staff reported there are adequate staff available and that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care.

Consumer information management systems meet the required standards. Archived records were being stored securely and all resident information is integrated and readily identifiable using relevant and up to date information.

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

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

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

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

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

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

Safe and appropriate environment

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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All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

There is single and double room accommodation and a mix of full ensuites and some bedrooms with a toilet and wash hand basin. Residents' rooms have adequate personal space provided. There are a number of lounges, dining areas and numerous alcoves. There is extensive decking and external areas for sitting and shading. There is a large secure external area provided for residents in the dementia unit.

There is an appropriate call bell system and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site and cleaning and laundry systems, including appropriate monitoring to evaluate the effectiveness of these 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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The service has clear policies and procedures which meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraint during the audit. There were no residents using an enabler. Staff education and competency occurs at least annually. The restraint approval committee undertakes regular quality reviews to ensure compliance with policies and to consider all aspects of restraint and enabler use. The restraint/enabler register is current.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff, and when appropriate, the residents and their families. There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported and discussed at staff and resident meetings and benchmarked internally and externally.

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	48	0	2	0	0	0
Criteria	1	98	0	2	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>The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). New residents and families are provided with a copy of the Code on admission and a copy is displayed on the main corridor wall in full view for residents, caregivers and visitors and also presented on the inside of residents’ bedroom doors.</p> <p>On commencement of employment all staff receive induction orientation training regarding residents’ rights and their implementation. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights in a manner that was individual to the resident’s needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the</p>	FA	<p>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.</p> <p>The residents’ files reviewed had consent forms signed by the residents, and/or family and enduring power of attorney (EPOA). Advance directives are signed by the resident if competent. Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and</p>

<p>information they need to make informed choices and give informed consent.</p>		<p>families/whanau were actively encouraged to be involved in their relative's care and decision making.</p> <p>Residents interviewed stated that they were able to make their own choices and felt supported in their decision making. Staff interviewed acknowledged the resident's right to receive, refuse and withdraw consent for care/services. Staff were able to demonstrate good knowledge around challenging behaviours as evidenced in progress notes, care planning and observed at the time of audit.</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>	<p>FA</p>	<p>All residents receiving care within the facility have appropriate access to independent advice and support, including access to cultural and spiritual advocate whenever required.</p> <p>Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff. The facility has access to an advocate and a specific Maori advocate through the district health board.</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>	<p>FA</p>	<p>There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident's progress notes and care planning, such as visiting the local shopping centre or community and school groups regularly visiting 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>	<p>FA</p>	<p>The facility manager is responsible for complaints and there are systems in place to manage the complaints processes. A complaints register is maintained. There is evidence that complaints are managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and displayed. Quality and Staff meeting minutes evidenced reporting of complaints to staff. Care staff confirmed this information is reported to them via staff meetings.</p> <p>One complaint has been received since the last audit, by the District Health Board (DHB) concerning the care of a resident. This complaint was investigated by the DHB and documentation evidenced corrective actions have been actioned by the facility and the complaint has been closed out. There have been no investigations by the</p>

		Ministry of Health, the DHB, the Accident Compensation Corporation (ACC), Police or Coroner since the previous audit.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is evidenced in the admissions agreement.</p> <p>The family/whanau and residents that were interviewed reported that the Code was explained to them on admission. The Code of Rights and process was also regularly discussed at family/resident meetings. Family/whanau and residents expressed that they were happy with the care at the facility and provided by the staff.</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>	FA	<p>The residents' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The family/whanau interviewed reported that the staff are meeting the needs of their relatives.</p> <p>The family/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.</p> <p>The family/whanau interviewed expressed no concerns in relation to residents' abuse or neglect. The family members reported that staff know their relatives well. This was also evidenced at the time of audit with observed interactions.</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,</p>	FA	<p>The registered nurse and facility manager reported that there are no barriers to Maori accessing the service. At the time of the audit there were 3 Maori residents whom affiliated with their culture. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture.</p>

values and beliefs.		
<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 spiritual, religious and cultural standard operating procedure documents that the admission process includes assessing specific cultural, religious and spiritual beliefs, which includes any cultural nutritional requirements. Staff liaise with family/whanau to ensure cultural or religious visits continue as appropriate.</p> <p>Education on cultural sensitivity and spirituality has been completed. Families and relatives interviewed were happy with the care provided by those staff who also identify with a different culture.</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>Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice was observed and evidenced in interviews with the clinical services manager, registered nurses, caregivers and care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by residents' GPs, links with the mental health services, hospice, the geriatrician and different DHB nurse specialists and consultants. Care guidelines are utilised as appropriate.</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>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit all residents spoke English.</p> <p>The family/whanau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidence adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes, accident/incident forms and at handover.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided. There are established systems in place which defines the scope, direction and goals of the organisation and UCG facilities, as well as the monitoring and reporting processes against these systems.</p> <p>A Business Plan and a Quality and Risk Management Plan for Ultimate Care Ranburn include a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Values, mission statement and philosophy are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.</p> <p>The facility manager (FM) provides reports to the governing body. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements and internal audit outcomes. The clinical services manager (CSM) reports on incidents and accidents and clinical indicators.</p> <p>The facility is managed by a facility manager (FM) and a clinical services manager (CSM). Both managers are registered nurses with current practising certificates. The FM has a number of years' experience in the aged care sector and has managed other aged care facilities. The FM has been in this current role since March 2016. The CSM, who is responsible for oversight of the clinical care of residents, has worked in various roles and is new to aged care. The CSM has been in their current role since April 2016. Review of the managers' personal files and interview of the FM and CSM indicates the managers undertake training in relevant areas. The regional operations manager and the audit and compliance manager for UCG provide support for the facility manager and clinical services manager.</p> <p>There is an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place that has four clinical services managers (CSMs) and is responsible for reviewing clinical issues and policies and procedures following feedback from each of the UCG sites. Each of the four CSMs is responsible for liaising with the UCG sites to ensure their participation in the process.</p> <p>Ultimate Care Ranburn is certified to provide hospital level care and rest home level care including dementia level care. On day one of this audit there were 23 hospital residents, 20 rest home residents and 10 residents requiring dementia level care.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed</p>	<p>FA</p>	<p>In the absence of the facility manager, the clinical services manager deputises. When the clinical services manager is absent, the facility manager with support from the registered nurses take responsibility for clinical oversight. The facility manager and the clinical coordinator confirmed their responsibility and authority for these roles.</p>

<p>in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>A quality and risk management plan guides the quality programme and includes goals and objectives. There was evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. Corrective action plans are being developed, implemented and reviewed. There is an internal audit programme and completed internal audits for 2015 and 2016 were reviewed. The collated resident and family satisfaction surveys for 2015 indicated that residents and families are satisfied or very satisfied with the services provided.</p> <p>There is an internal audit programme in place and completed internal audits for 2015 and 2016 were reviewed. Quality improvement data is being reported to UCG head office electronically as well as to staff via various meetings. Quality, registered nurse, staff and health and safety meetings are held monthly. Various clinical indicators and quality and risk issues are discussed at these meetings and documented. Minutes of meetings along with clinical indicator reports, graphs and benchmarking data is available for staff. Resident meetings are held monthly and residents confirmed any issues raised are dealt with by management. Although meeting minutes evidenced who is responsible for any corrective actions, there was no evidence of the timeframe for the completion of the corrective action.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and references legislative requirements. Policies and procedures have been reviewed and are current. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for the service delivery.</p> <p>Actual and potential risks are identified and documented in the hazard register. The hazard register identified hazards and showed the actions put in place to minimise, isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is responsible for hazards and demonstrated good knowledge. Staff confirmed they understood and implemented documented hazard identification processes.</p> <p>A quality improvement initiative has been awarded continuous improvement relating to the environment in the dementia unit.</p>
<p>Standard 1.2.4: Adverse</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG electronic database and filed in resident files. Data included summaries and registers of</p>

<p>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>various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and behaviour. Documentation reviewed and interviews of staff evidenced appropriate management of adverse events.</p> <p>There is an open disclosure policy. Communication with families following adverse events involving the resident, or any change in the resident's condition was documented in the resident's files. Family confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. There have been two outbreaks notified to the DHB since the last audit. Systems have been reviewed and staff have received education relating to one outbreak where there was a delay in notifying the DHB. Policy and procedures comply with essential notification reporting (eg, health and safety, human resources, infection control). The audit and compliance manager confirmed there has been one essential notification to the Ministry of Health since the last audit.</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>There are policies and procedures relating to human resources management. Job descriptions that outline accountability, responsibilities and authority, employment agreements, completed orientations, competency assessments and police vetting were on staff files.</p> <p>The inservice education programme is the responsibility of the facility manager and the clinical services manager. Inservice education is provided at least monthly. Staff are encouraged to complete education modules via New Zealand Qualifications Authority Unit Standards. All staff working in the dementia unit have commenced or completed the dementia specific modules. Individual records of education are maintained for each staff member as are competency assessments. There are attendance records for each education session. External speakers are used for some of the inservice sessions and staff also attend external education.</p> <p>There is an orientation/induction programme and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Essential components of the service are covered at orientation.</p> <p>Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.</p> <p>Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals.</p> <p>Four of the nine registered nurses have completed the interRAI education.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of one registered nurse and three caregivers, one in each of the three areas. The facility manager and clinical services manager are on call after hours. Care staff reported there were adequate staff available and that they were able to complete the work allocated to them. Residents and family interviewed reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover was provided.</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>The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all residents' information sighted. Clinical notes were current and integrated with GP and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's record reviewed. No personal or private resident information was observed to be on public display during the days of audit. Archived records were being safely held on site for seven years.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The resident admission agreement is based on the Aged Care Association agreement. The residents' records reviewed have signed admission agreements by the resident/family or EPOA.</p> <p>Vacancies are updated daily through Eldernet. Staff contact the facility manager if enquiries are made by potential perspective residents and/or their family members outside of normal working hours and an enquiries form is completed.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated</p>	FA	<p>The service uses the DHB's processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Communication between the two services and with the family occurs prior to transfer and any concerns are</p>

transition, exit, discharge, or transfer from services.		documented and included in the transfer information.
<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>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, the process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. At the time of audit one resident was self-administering medications and stored their inhaler medications in their bedrooms.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in a medicine trolley individually in the three treatment rooms which is locked when not occupied. A locked safe is used for controlled medications and the medicine register was sighted. Medications that require refrigeration are stored in separate fridges with recorded temperatures documented.</p> <p>The 14 medicine charts reviewed have been reviewed by the GP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (PRN) medications identified had the reason stated for the use of that medication. There is a specimen signature register maintained for all staff who administers medicines. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident and a pharmacy medication/tablet identifying sheet.</p> <p>There are documented competencies sighted for designated care staff responsible for medicine management. The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management.</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>	FA	<p>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. Kitchen staff interviewed had a very good understanding of food safety management and have completed ongoing updated food safety training.</p> <p>There is a six week rotating menu that has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review. Also evidenced was support, intervention and care planning from a speech language therapist.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks</p>

		<p>24 hours a day.</p> <p>The kitchen also offers residents a variety of cereals for breakfast, a vegetarian and main option for lunch including a desert and a lighter menu option for dinner. All main meals are supported by morning and afternoon tea which includes home baking. There is a small kitchenette situated in the rest home facility where residents/family can make their own hot and cold beverages and heat up food in a microwave.</p> <p>All meals are cooked and served directly from the kitchen for rest home and hospital residents and served in the adjacent dining room. A hot plate is used to transport meals to the secure unit. Residents have the option of trays in their rooms however all residents are encouraged to have their meals in the dining rooms to encourage appetites and socialisation.</p> <p>The facility provides a meal on wheels service (Monday to Friday) to the elderly in the community, the service is supported by volunteer drivers.</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>The clinical services manager interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</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>The service has implemented the electronic interRAI assessment and specific assessment tools for all residents remain paper based. Assessments are carried out by a registered nurse appropriate to the level of care of the resident and includes falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life, self-medication and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>The residents' files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident's family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure ulcer risk assessments.</p> <p>The family/whānau interviewed reported their relative receives 'above and beyond the care required' to meet</p>

		their relative's needs.
<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>The nine residents' files reviewed have electronic care plans that address the resident's current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in the residents' files. Also evidenced is the assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The caregivers interviewed demonstrated knowledge about the individual resident's they care for.</p> <p>The residents' files reviewed included diversional therapy care plans identifying the resident's individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files showed input from the clinical services manager, registered nurse, care and activity staff and medical and allied health services. The registered nurse and caregivers interviewed reported they receive adequate information to assist with the resident's continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication book.</p> <p>The family/whanau interviewed reported they were very happy with the quality of care provided at the service.</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>Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the day of the audit, the registered nurse and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired goals. The registered nurse and caregivers interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer,</p>	FA	<p>The activities programme uses a framework to empower the residents both young and older to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities coordinator adapts activities to meet the needs and preference of choices of the young and aged care residents.</p>

<p>activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>The facility has two activity co-ordinators (one of whom is training towards obtaining qualification as an occupational therapist); combined they work who a total of 66 hours per week, which also includes one day in the weekend. They attend regular alternative monthly community diversional therapist group meetings. The weekly activities plan/calendar sighted is developed based on the resident's individual needs and interests and can be easily adapted and changed depending on the resident's physical ability, interest and reaction at the time. The activities staff advertises the upcoming activities on the calendar by providing this to residents on the notice boards through the facility. Regular activities include church services, happy hour, regular visiting entertainment and includes trips to other events occurring in the community such as weekly craft day, daily community day programmes and community set events and men's and ladies specific activities. Staff and residents from surrounding facilities are regularly invited to attend inter facility competitions (eg, Bowls). For residents who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The care staff interviewed stated that they have access to activities to support residents after hours and on the weekends. Staff promote social interaction by inviting and encouraging all residents from each level of care within the facility to join in activities together in the main lounge.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements over a 24 hour period. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file three monthly.</p> <p>The outside environment provides easy access to outside garden areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.</p> <p>All residents and families interviewed stated that they were happy with the activities on offer and families and visitors felt included when they visited.</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>The residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or is not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans are sighted for wound care, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans are documented in the residents' progress notes. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition.</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>There are two GPs who combined visit from the same GP practice the residents at the facility which also includes an on call component. The RN in discussion with the GP will arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident's file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The use of the 'ISBAAR' communication tool is utilised to promote accurate and precise information between the two parties. The GP interviewed reported that appropriate referrals to other health and disability services are well managed from the facility.</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>	FA	<p>There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are throughout the facility and accessible for staff. The hazard register is current. Education to ensure safe and appropriate handling of waste and hazardous substances has been provided to staff.</p> <p>There was protective clothing and equipment in the sluice rooms and laundry that is appropriate to recognised risks. Protective clothing was observed 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>	FA	<p>A current building warrant of fitness was displayed. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs. Families of residents with dementia confirmed the dementia unit has lots of space for their relative to enjoy. (Refer Standard 1.2.3)</p> <p>There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. Maintenance is currently undertaken by a contractor. The testing and tagging of equipment and calibration of bio-medical equipment is current.</p> <p>There are external areas available that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas with numerous decking</p>

		<p>and a safe, secure external environment for residents in the dementia unit. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Bedrooms have either full ensuites or ensuites consisting of a wash hand basin and a toilet. There are adequate numbers of communal bathrooms and toilets throughout the facility. Residents reported that there are sufficient toilets and they are easy to access.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate personal space provided for residents and staff to move around within the bedrooms safely. Apart from two double bedrooms currently used for single accommodation, all bedrooms are single. Residents spoke positively about their accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheel chairs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	FA	<p>There are a number of areas for residents to frequent for activities, dining, relaxing and for privacy. Residents, family and staff confirmed these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>

<p>accessible areas to meet their relaxation, activity, and dining 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>	<p>FA</p>	<p>All laundry is washed on site. Residents and family reported the laundry is managed well and resident's clothes are returned in a timely manner.</p> <p>There are dedicated cleaners on site who have received appropriate education. A cleaner and training records confirmed this. Chemicals are stored in a locked cupboard. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an approved fire evacuation plan. There is an evacuation policy on emergency and security situations that covers all service groups at the facility. A fire drill takes place six-monthly with a copy provided to the New Zealand Fire Service. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>There is always at least one staff member on duty with a current first aid certificate.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs.</p> <p>There are call bells to alert staff. Residents and families reported staff respond promptly to call bells.</p> <p>Contractors must sign in and out of the facility. They are also made aware of any hazards on site. The external doors are locked in the evenings.</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</p>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by heat pumps. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p> <p>The infection control coordinator, who is a registered nurse, holds accountability and responsibility for following the programme in the infection control manual. The infection control coordinator monitors for infections by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each staff meetings. If there is an infectious outbreak this is reported to staff, management and where required to the DHB and public health departments.</p> <p>The infection control coordinator interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, staff communication book, one to one, shift handover and in resident's documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. Residents who have infections are encouraged to stay in their rooms if required.</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</p>	FA	<p>The registered nurse has the role of infection prevention and control coordinator. Infection control issues are discussed at staff and resident meetings. The facility has the support of a clinical infection control specialist nurse who is available for advice on infection prevention. Advice can also be sought from different external sources including the laboratory diagnostic services and GP. The infection control coordinator has undertaken a yearly external course on infection control. The registered nurse and caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed.</p>

organisation.		
<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>An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, including antibiotic use, MRSA screening, bandaging, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The registered nurse and caregivers interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the enrolled nurse. Infection control in-service education sessions are held and resident education is provided, as and when appropriate.</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>All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly surveillance report. The service monitors wounds, pressure injuries, urinary tract infections, upper and lower respiratory tract infections, skin and soft tissue, oral, eyes, gastroenteritis infections. Antibiotic use is also monitored and evidenced as discussed with the GP. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff and where appropriate resident meetings and is benchmarked internally and externally.</p> <p>Infection rates for scabies were elevated in May 2015. There was also a noted increase in respiratory infections in December 2015. Corrective action plans for both outbreaks sighted showed interventions to reduce and</p>

		<p>minimise the risk at the time and ongoing prevention implemented which resulted in a review of the facility's policies and procedures and an increase in staff, resident and family training/education. One resident in the last four months has had multiple infections due to their chronic medical history over several months. Care planning and intervention/evaluation was evidenced to show how staff were reducing and minimising risk, trends and actions to take to reduce the infection rate for this person.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service demonstrated that the use of restraint is actively minimised. There were eight residents using restraint during the audit. There were no residents using an enabler. The restraint coordinator is a registered nurse and was unavailable, however the CSM demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register is current and updated. The policies and procedures have good definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers.</p> <p>There is a restraint approval group that meets six monthly. Meeting minutes confirmed this.</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>	FA	<p>A registered nurse is the designated restraint coordinator. A signed job description was evident in the restraint folder. Responsibilities of the restraint coordinator and approval committee are clearly outlined. Restraints to be used for the resident are approved by the restraint approval group prior to commencing the restraint. The restraint approval group is composed of the restraint coordinator, the facility manager, the clinical services manager, an activities coordinator, the GP, and the physiotherapist who reviews the restraint use every six months. The GP completes three-monthly review of the restraints in use.</p> <p>Restraint use is discussed in the quality and staff meetings. Staff confirmed their knowledge of the restraint processes.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in</p>	FA	<p>Completed restraint assessment forms prior to commencing any restraint were in the files of those residents using restraint. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. Long term care plans clearly documented desired outcomes. Staff demonstrated good knowledge in maintaining culturally safe practice when completing assessments for restraint use.</p>

relation to use of restraint.		
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Low	<p>Safe use of restraint is actively promoted. Restraint usage has decreased from 13 at the last audit to eight residents currently using restraint. There is a current and updated restraint/enabler register. The risk management plans ensure the resident's safety while using restraint. Staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. There are restraint minimisation policies and procedures that are accessible for all staff to read. There were no restraint-related injuries reported. There were monitoring forms for all residents who are using restraint; however, staff are not consistently signing the restraint monitoring forms following each monitoring event.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Restraint use is evaluated regularly. Consents and evaluation forms were signed by the GP and the residents' families. The evaluation form included the effectiveness of the restraint and the risk management plans documented in the long term care plans. Staff confirmed their feedback was obtained by the restraint coordinator when evaluating the restraint in use. The restraint approval group evaluated the restraints in use at least six monthly.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint approval group is responsible for monitoring and reviewing restraint. Restraint is also monitored through the internal audit programme. Identified issues are discussed in the quality and staff meetings as well as additional education that is required to support staff. This has included education relating to restraint and challenging behaviour. Staff had good knowledge relating to managing challenging behaviour. Staff were observed managing challenging behaviour during this audit. There was good evidence in resident's care plans to guide staff concerning any challenging behaviours.</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>Corrective action plans are being developed, implemented and reviewed to address deficits identified. Various meeting minutes evidence who is responsible for the corrective action; however, there is no evidence of any timeframes documented for the completion of the corrective actions.</p>	<p>Minutes of meetings do not include a timeframe for the completion of corrective actions identified.</p>	<p>Provide evidence that meeting minutes include the timeframe required for the completion of corrective actions.</p>

				180 days
<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>	PA Low	<p>There were no restraint-related injuries reported. Restraint usage has been actively reduced. Monitoring forms were evidenced for all residents who are using restraint. Sign off by staff for each monitoring episode is not consistent. That is, staff are clustering monitoring times and signing off once per shift.</p>	<p>Signing off for each monitoring episode is not consistent. Staff are clustering monitoring times on the monitoring form and signing off once per shift.</p>	<p>Provide evidence that monitoring forms are completed correctly.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	CI	<p>Following feedback and discussions with residents’ families and staff in the dementia unit, and observing the behaviours of residents, a quality initiative was put in place to enhance the environment in the dementia unit for residents. It was acknowledged that the dementia unit had become ‘sterile and institutional’ in appearance. Residents were restless and exhibiting challenging behaviours. Meetings and discussions were held with families of the residents in the dementia unit, the staff and management. The main purpose of the project was to change the physical environment to support a variety of activities, to ensure optimum levels of stimulation for the residents, and that any change had to be environmentally safe. The design also had to take into account factors such as ethnic diversity, the needs of visiting families and the potential to integrate community activities.</p> <p>The decision was made to look at design arts that are effective within dementia units across the sector. A project team was formed consisting of UCG management and staff, and Ranburn staff to come up with designs that would best suit the layout of the dementia unit. Various companies were invited to</p>	<p>As a result of a quality initiative around the environment in the dementia unit, murals showing different scenes were erected on the walls and doors to improve the physical environment for residents and their families. This has resulted in a number of changes in residents’ behaviour. Residents are calmer and there is less ‘sun-downing and agitation exhibited. Residents also enjoy conversations about the items on the murals with other residents, family and staff.</p>

		<p>participate in the design process to achieve maximum benefit for the residents. Following suggestions and feedback from the residents' families and staff, wall and door mural selections were made and erected in the dementia unit.</p> <p>Documentation evidenced that since the murals have been installed families of residents and staff have noticed significant changes in the residents. Residents are now conversing with each other and family members about items on the murals. The murals have a calming and soothing effect for residents and there is less agitation. This was observed during the audit. Residents relate to the pictures of animals and the countryside which has reduced the effects of 'sundowning'. Relatives reported that their children now enjoyed visiting the unit and commented on the calmness within the unit and that residents no longer try to get out the doors.</p>	
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End of the report.