

The Ultimate Care Group Limited - Ultimate Care Maupuia

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 Maupuia
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 June 2016 End date: 2 June 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:	21

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ultimate Care Maupuia is situated in Miramar in the Wellington region. It provides residential care for up to 31 residents who require hospital or rest home level care, however there is a current refurbishment process occurring that has reduced the availability of beds temporarily. Occupancy on the day of the audit was 21 residents. The facility is operated by The Ultimate Care Group Limited.

This certification audit was conducted against the relevant Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, residents' and staff files, observations, and interviews with residents' families, management and staff. A general practitioner and an independent advocate were also interviewed. Residents and family provided positive feedback on the care and services provided by the facility.

The facility is currently managed by an experienced relief manager following the very recent departure of the previous manager who has taken up another position within the group. She was also present at the audit.

A continuous improvement has been awarded following an initiative to improve the dining experience for residents at the facility. Three areas were identified as requiring improvement around legibility of names and designations on records and care planning.

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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Systems and processes are in place to ensure that services provided to residents respect their independence, personal privacy, individual needs and dignity. Staff receive regular training on resident rights and their implementation in daily practice. Staff also receive regular training related to ensuring residents are free from discrimination or abuse/neglect. Family and residents confirmed that residents were treated in a professional and respectful manner.

Detailed clinical policies, the ongoing monitoring of a variety of clinical indicators, and well-established professional networks with a range of specialist health professionals help ensure that services provided to residents are of an appropriate standard.

Residents and their families reported their satisfaction with the services provided, and of the open and timely communication with staff.

An effective complaints system is in place with all response timeframes clearly documented. The one concern raised this year was low level and was resolved satisfactorily.

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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Ultimate Care Maupuia has been managed until very recently by an experienced and well qualified manager who oversaw the day to day running of the facility. A new manager with significant management experience has been recruited and will start later in the month of the audit. The management at the facility is supported by the regional manager and the quality management team at The Ultimate Care Group Ltd national office. Planning is detailed and is responsive to any changes required both at legislative and facility level.

A comprehensive quality and risk management system is in place with robust reporting. There is a quality improvement plan which includes an annual calendar of internal audit activity which monitors health and safety, infection control, medication, resident care, all administration functions, human resources processes and the monitoring of the quality initiatives that are in place. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective actions planning, feed into the quality improvement cycle to manage any further risk and ensure continuous quality improvement occurs.

A sound recruitment and appointment system is in place and staffing levels meet all the requirements. A comprehensive training programme is evident to maintain a high level of competence of all staff. Staff reported good support from both their colleagues and the management.

Residents' private information, both in electronic form and hard copy, is securely maintained.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses are responsible for all aspects of resident assessment, care planning and evaluation of progress towards identified goals. These are completed in a timely and comprehensive manner. Care plans are individualised and include extensive clinical information, together with input from residents and families. Residents are regularly reviewed by the doctor and referred in a timely manner if their clinical needs change.

Appropriate processes are in place to ensure continuity of service delivery. Residents' progress notes are updated each shift and all staff have a verbal handover at the start of their shift. Registered nurses are on duty 24 each day with a senior registered nurse available on call after hours.

Residents and their families expressed their satisfaction with and enjoyment of food services. The individual food preferences and dietary needs of residents were respected and catered for. The kitchen was well organised and maintained in a clean and hygienic manner. Staff have the appropriate food safety qualifications and all aspects of food services were well managed.

An enthusiastic recreation officer manages the activity programme, which offers residents a variety of individual and group activities. Residents are encouraged to maintain their links with the community and a facility van is available to take residents on outings or attend community activities.

All aspects of medication management are safe and consistent with legislative requirements and best practice. Medications are administered by registered nurses all of whom have been assessed as competent in relation to medicines management.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility is well maintained and provides a comfortable and homely environment. The residents' rooms and the communal areas are clean, well ventilated and kept at a comfortable temperature for residents. The bathrooms are currently being refurbished to upgrade them to meet the appropriate standards to encourage independent use.

Well maintained and safe outside areas are able to be accessed by residents, with most rooms opening out onto patio or deck areas.

The building has a current building warrant of fitness.

The management of waste and hazardous substances is safely managed by staff who are trained in these processes.

Emergency procedures are well documented for ease of use and clear instructions are located around the facility by the fire alarms and all main exits. Regular fire drills are held and sprinkler systems are installed in case of fire. Adequate civil defence supplies, water and food are kept on site in case of an emergency and access to a generator is available if required.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has policies and procedures that meet all the requirements of the standard and these are followed for all enabler and restraints in use. Restraint is only used as a last resort when all other options have been explored. The facility is committed to providing a restraint free environment. A comprehensive assessment, approval and monitoring process with regular reviews is occurring. The use of enablers is for the safety of residents in response to individual requests. These are reviewed regularly.

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.

Infection prevention and control is well managed. Staff have access to a range of personal protective equipment and receive ongoing training related to infection control.

Well-established processes are in place to ensure infection surveillance is systematic. Appropriate action is taken as required in relation to surveillance results, including effectively communicating these results with staff.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	1	2	0	0
Criteria	1	97	0	1	2	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 Acting Clinical Services Manager (ACSM) advised that education related to the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is included in the orientation for all new staff, and is also offered at least annually. This was confirmed in staff interviews and education records. On interview staff demonstrated a clear understanding of the Code and were able to explain how this would be incorporated into their everyday practice.</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>Each resident, and/or their enduring power of attorney (EPOA), completes a comprehensive consent form at the time of admission. All residents’ records reviewed included completed consent forms. Consent is reviewed on an as-required basis, such as when a resident’s needs change, or additional medical/surgical treatment is required.</p> <p>Residents confirmed on interview that they were supported to make informed choices and that their consent was obtained and respected. Family members also confirmed they were kept informed about what was happening with residents and were also consulted in situations such as when consideration was being given to transferring the resident to a public hospital.</p> <p>The admission documentation completed by each new resident and/or their family member identified inclusions and exclusions in service. A database is maintained to ensure that signed admission</p>

		<p>agreements are held for every resident.</p> <p>The ACSM advised that where appropriate residents are encouraged to complete Advance Care Plans. Several of these plans were sighted in residents' records, together with the doctor's assessment of the resident's competency to make these types of decisions. All residents' files included their resuscitation status, which had been signed by the doctor.</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>Residents are given a copy of the Nationwide Health and Disability Advocacy Service (Advocacy Service) brochure as part of the admission process, with additional copies available at reception. An independent advocate visits the facility twice-weekly and is always available on call. Residents and family members confirmed on interview their awareness of the Advocacy Service and how to access this, as well as the services offered by the independent advocate.</p> <p>Information on the Advocacy Service is included in the staff orientation programme and in the ongoing education programme for staff. This was confirmed in staff orientation and training records. On interview, staff demonstrated their understanding of the Advocacy Service, including contact details.</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>If residents are well enough, they are encouraged to maintain their community interests including visiting and even staying overnight with their families. Outings are organised that enable residents to participate in community events, while community groups and entertainers visit the facility regularly. Residents are also supported to access health care services outside of the facility, such as visits to the dentist or the optometrist.</p> <p>Visitors are encouraged at the facility, which has unrestricted visiting hours. All family members interviewed stated they felt very comfortable visiting the facility and also felt welcome.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy and associated forms that meet the requirements of Right 10 of the Code. These are provided in the first instance to all new residents on admission. Forms are also available at the front desk and in the nurses' station. The facility manager takes responsibility for investigating and managing complaints. All complaints are recorded in the complaints register. A risk rating is applied to each complaint/concern and a risk matrix has been developed nationally to guide staff. Any of a serious nature are immediately notified to the quality manager who will then provide support if required. Every complaint is then entered into the organisation's electronic quality system.</p> <p>The complaints register was reviewed and the only complaint received over the past six months was well documented with copies of all responses made. This met the required timeframes as per the</p>

		<p>organisational policy, was of a minor nature and resolved satisfactorily. The quality committee review any complaints at their monthly meetings. Corrective actions are initiated as appropriate and form part of the quality improvement process. The manager also reported a number of compliments have been received over the past year. These are also recorded and shared with staff.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The ACSM explained that each new resident and their family are provided with a copy of the Code and information on the Nationwide Health and Disability Advocacy Service (Advocacy Service) as well as the facility Code of Conduct as part of the admission process. This is discussed with them at the time of their admission by the ACSM and/or the facility manager, and any questions answered at that time. If the resident/family require any further information at a later date, this is discussed with them when required. Information on the Code, and the Advocacy Service, is available at reception, as well as displayed in poster form around the facility.</p> <p>An independent advocate visits the facility twice a week, and is also available at other times if required. This advocate explained that they are available to work with both residents and/or families, and they also chair the bi-monthly resident meetings.</p> <p>On interview all residents and family members confirmed their understanding of resident rights and had been given information about these and the Advocacy Service. They also confirmed that if they did have any concerns they would feel comfortable raising these with 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>With the exception of a shared room available for couples, all residents have a private room, many of which had been personalised by the resident concerned. Residents and families stated on interview that they were treated respectfully and their individual needs were meet. During the audit visit, staff were observed to maintain resident privacy when undertaking personal cares, to knock on closed doors before entering, to address residents by their preferred name and interact with residents in a warm and pleasant manner. Residents' privacy was protected when they were using shared toilets and showers.</p> <p>All residents' records reviewed included documentation of the resident's individual cultural, religious and social needs, values and beliefs which had then been incorporated into their lifestyle plan. Lifestyle plans also included strategies to maximise the resident's independence. There was evidence that these plans had been developed in conjunction with the resident and/or their family.</p> <p>All staff undergo a police check as part of the employment process and staff human resources records</p>

		confirmed those checks had been completed and that referee checks had also been completed. The service's policy related to abuse and neglect was well understood by those staff interviewed. They were able to provide examples of what would constitute abuse and neglect and the actions they would take if they suspected this. Staff education records confirmed that annual training related to abuse and neglect is held.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is a range of documentation, including policies and a Maori health plan, which help guide service provision for residents who identify as Maori, although there were no residents identifying as Maori at the time of the audit. The ACSM advised that a staff member who identifies as Maori is available as a resource for staff and either they or a lay chaplain were responsible for blessing the rooms of deceased residents. The service has established links with the Capital and Coast District Health Board (CCDHB) Community Ora Liaison Nurse, as well as the CCDHB Maori Health Unit, who are able to offer cultural support and advice as required.</p> <p>Cultural beliefs and related requirements are identified as part of the admission process for residents and are then incorporated into the relevant sections of the care plans.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service demonstrated a commitment to ensure recognition and respect of each resident's culture, values and beliefs. Residents' preferred name, personal preferences and special requirements were included in all care plans reviewed, with interventions noted to ensure these were met. There was also evidence in those care plans of the resident and/or their family being involved in their development. The service has also instigated an initiative to support staff to gain a greater understanding of individual residents, with a selected resident featured each fortnight in a 'my name is' profile in the staff room.</p> <p>All residents and family members advised on interview they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected.</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>The ACSM advised that the orientation for new staff includes education related to all forms of discrimination and exploitation. Management ensure they lead by example, and staff are regularly reminded about professional boundaries. There is ongoing education from an Age Concern representative related to discrimination on an annual basis, which was confirmed in staff interviews and training records.</p>

		<p>During interviews, staff were able to demonstrate a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. All residents and family members interviewed stated that residents were free from any type of discrimination or exploitation.</p> <p>On interview, the doctor confirmed their satisfaction with the standards of service provision and confidence that residents are not discriminated against in any manner.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service uses a range of strategies to ensure resident services are of an appropriate standard. These include staff having access to clinical policies on a range of topics, such as wound care, diabetes management and pain management, which reflect best practice. The quality monitoring system includes a number of clinical quality indicators which are carefully scrutinised to ensure best practice is being maintained. A multifaceted quality project is currently underway which is designed to reduce the number of resident falls.</p> <p>The ACSM also advised that service has well-established and extensive professional networks which support the maintenance of appropriate practice standards. There was evidence in the residents' records of timely referrals to a range of specialist staff from the CCDHB, such as for wound care and diabetes, the speech-language therapist, psychogeriatric services, and physiotherapist.</p> <p>On interview, residents/families and the doctor confirmed their satisfaction with the standard of care provided to residents.</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>Evidence was sighted in all residents' records reviewed of resident/family input into the care planning process, together with open disclosure and effective communication with residents/families. Communication was documented in family communication sheets, on the accident/incident form and in the residents' progress notes. The next of kin is provided with a written report on the resident's progress every three months, and residents and families are invited to participate in the six-monthly multidisciplinary resident reviews.</p> <p>The independent advocate chairs the two-monthly residents meeting (minutes sighted). All family members interviewed stated they were informed in a timely manner about any changes to the resident's status.</p> <p>The service employs a number of staff who also speak languages other than English, and the ACSM also provided contact details for translator services should these be required.</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>Ultimate Care Maupuia is part of a national organisation who has a chief executive officer (CEO) to manage an executive team to support their business activity. A chief operating officer manages the team that supports their aged care facilities based at the national support office. Each facility has its own annual quality and risk management plan written by the facility manager, which is informed by the national strategic and business plan and approved by the relevant regional manager. The vision, mission and goals of the organisation are clearly documented and these are integrated into the planning at each facility. These are reviewed by the executive team annually. A comprehensive suite of policy and procedure documents was sighted with the focus being on quality aged care provision. The 2016-2017 quality and risk management plan detailed the facility's planned goals and actions for the current year.</p> <p>The manager reports to the regional manager with whom regular face to face and phone meetings are held. The previous manager, who was present at the audit, was in the role eight months and prior to that had been employed in the aged care sector for a number of years. The current national relief manager has had significant experience in the sector and will provide support during the transition period for the incoming manager.</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>Any absences by the manager are covered by the clinical service manager who performs the role. She is also supported by the national team who are available at all times to provide any additional management support as appropriate. There is an ongoing close relationship with the three managers of all the Ultimate Care Group (UCG) facilities in the area who provide reciprocal management support to their colleagues as required.</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>There is a detailed quality and risk management plan which is reviewed annually. The current plan is for the 2016 calendar year. The quality improvement programme is led by the manager with support from the clinical service manager (CSM). Support and oversight is provided by the national quality governance group. A range of quality indicators are being monitored throughout 2016 with key indicators prioritised for the current year. For Maupuia these are medication, falls prevention, a reduction in urinary tract infections (UTIs) and challenging behaviour management strategies. The other key components of the quality system include reporting and analysis of adverse events, infection control, health and safety, pressure injuries, weight loss, skin tears and wound management, restraint, education and training and all quality improvement activities.</p> <p>The quality improvement plan includes an annual calendar of internal audit activity and the month</p>

		<p>when each audit is completed. The results of these are graphed and relevant corrective actions raised if needed.</p> <p>The quality management system is informed by regular reporting and analysis of data collected from all the indicators which are fed into the national electronic quality system. This enables national benchmarking and data analysis to be done at both facility and national levels. Collated reporting, including graphed information, is sent to the facility and these are reviewed at the quality meetings held monthly. Relevant corrective actions are then put in place and monitored. Monthly quality committee, staff, health and safety committee and clinical meetings review and discuss the quality indicators with any new quality initiatives developed and introduced. The minutes of the years meetings, which all have set agendas which cover all the relevant quality and risk reports, were sighted. Resident bi-monthly meetings also include relevant updates on quality initiatives as appropriate.</p> <p>The manager interviewed confirmed reporting on quality indicators is done on a weekly basis as well as data around staffing levels, financial reporting and occupancy. Monthly reports are completed with results from internal audits and the resulting corrective actions which are monitored regularly.</p> <p>Policies sighted are all current with staged reviews occurring on a three year cycle. A document control system is in place. Any policies that change are sent to the facilities for updating. All staff must read all new and revised policies and sign when this has been completed.</p> <p>The facility risk register detailed risk factors, risk categories, impact and probability scales and impact of each after controls are applied, actions to be taken to control each risk and the people (positions and committees) responsible for them. These risks are reviewed continuously.</p> <p>All new hazards are entered into the quality recording system and each facilities hazard register is then automatically updated.</p> <p>Staff interviewed reported they are involved in and kept well informed of all quality activity at the facility.</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</p>	<p>FA</p>	<p>There is a detailed national policy on incident management and reporting which describes the process for completing the incident / accident report form and what action staff take once they have completed the form. Any serious incidents / accidents are reported to head office. There are a range of other documents (policies, procedures and guidelines) to assist staff in investigating incidents and accidents and taking appropriate action.</p> <p>All individual events are followed up by the registered nurse on duty daily. They are then reviewed by the clinical service manager and the facility manager with details entered into the quality reporting</p>

<p>family/whānau of choice in an open manner.</p>		<p>system. There is monthly analysis of all incident / accident reports which are categorised according to each event type. This is sent back to the facility and the quality committee who then review the collated data at their monthly meetings and raises any corrective actions that are required and monitor those already in place.</p> <p>The register was reviewed. Each form included documentation of notification of family and medical professionals where relevant. A copy was also filed onto the resident's notes. All relevant corrective actions raised are communicated to staff, reviewed, progress tracked and preventative measures implemented. All staff interviewed across all service areas understood they are responsible for reporting and responding to incidents and confirmed they understand and follow the required processes. They also reported they get relevant feedback once the incident has been reviewed and investigated.</p> <p>The manager confirmed any incidents that require essential notification are reported to the relevant authority at the DHB, Worksafe New Zealand or other relevant bodies and the electronic system also flags when this is required.</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>A comprehensive set of policies and procedures have been implemented nationally and reflect good employment processes. All recruitment is currently managed by the manager, with support from the CSM for all clinical appointments. The manager reports that when a vacancy occurs, head office manage the initial advertising then the responsibility for shortlisting, interview, reference checks and police checks is done internally by the facility. Competency checks are completed prior to any appointments. Professional qualifications are verified and filed. Other professionals who are independent of the facility as well as independent contractors also had relevant checks completed. All annual practising certificates (APCs) are current and securely filed. Current competencies, including those for the interRAI assessors for the facility were sighted.</p> <p>The staff files reviewed have all the required documentation completed and current performance appraisals had been completed. Also included were relevant training certificates for individuals.</p> <p>All staff had received a comprehensive orientation. This covered the introduction to the facility and the policies. All staff interviewed confirmed their orientation process was a detailed one with a 'buddy' system to help them learn their roles. They felt able to carry out their duties as required once their orientation process was completed.</p> <p>A comprehensive annual training plan is in place. This covered all the requirements for aged care providers. The manager also reported individual electronic attendance records are kept to monitor the attendance of staff at all training sessions. All staff are required to attend training sessions directly associated with their role as well as full staff attendance at emergency evacuations training. There are</p>

		<p>a number of modules that are compulsory for all staff and this includes training about the Code, infection prevention and control, pressure injuries, manual handling, challenging behaviour, complaints and informed consent. Care staff are encouraged to complete either Aged Care Education (ACE) or Careerforce training. Records reviewed evidenced comprehensive training occurs for staff at the facility. A total of three registered staff are interRAI trained and pressure injury training has been completed by all care staff. Any staff unable to attend particular sessions must complete on line or paper based follow up training.</p> <p>Staff interviewed report they have significant training opportunities and confirmed management are very encouraging to staff to upskill themselves.</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>A national staffing rationale policy is in place. This describes the process for developing rosters in each facility. All rosters are maintained by the current manager and are prepared two weekly in advance using the organisational tool. The tool is able to ensure safe staffing levels are in place as levels of need change and hours are set according to the current needs of the residents at the facility at any one time.</p> <p>The rosters were sighted for the week of the audit and also for the next week. These confirmed adequate cover for the acuity needs of current residents. The manager reported any absences are usually able to be covered with limited use of agency staff required. At least one staff member on duty at all times has a current first aid certificate and there is 24 hour seven day a week (24/7) RN coverage.</p> <p>Staff reported they are happy with the staffing levels.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>PA Low</p>	<p>Resident-related information is kept in both hard-copy and electronic files. These files were maintained securely. Electronic files were password protected and can only be accessed by designated staff. Some hard copy information is kept in the nurses' stations, which were observed to be kept locked when no staff were present. Archived material was also kept securely but was easily retrievable.</p> <p>All components of the residents' records reviewed included the resident's unique identifier. The clinical records reviewed were well-organised and integrated, including information such as medical notes, reports from other health professionals and laboratory results.</p> <p>Detailed residents' progress notes were completed every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes do not clearly identify the name of the person making the entry.</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>	<p>FA</p>	<p>The ACSM outlined the processes associated with admission to the service. Prospective residents are provided with detailed information about the service, including the admission criteria and the processes that must be completed prior to admission. They and their family/whanau are encouraged to visit the facility prior to admission.</p> <p>Residents can only be admitted when their level of required care has been assessed and confirmed by the Needs Assessment and Service Coordination Service (Capital Coast Care Coordination Service).</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them as part of that process.</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>	<p>FA</p>	<p>When a resident is transferred to acute care services the facility uses the DHB's 'yellow envelope' system to facilitate continuity of care and the exchange of relevant information. When a resident is transferred, the ACSM advised that a variety of information, such as copy of the medication chart, advanced directive, resuscitation status and a referral form, go with the resident. An example of a completed referral form was sighted in the file of a resident recently transferred to an acute facility.</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>Registered nurses administer all medication in the facility, with senior caregivers acting as 'medication second checkers' as required. All these staff have been assessed as competent in medication administration and records of competency assessments sighted. An observation of a medication round confirmed that medications were administered in a safe and appropriate manner. All of the ten medication charts reviewed contained a current photograph of the resident, and their allergy status. Medications were charted in an appropriate manner, discontinued medications initialled and dated, medications were reviewed at least three-monthly and medication administration records were complete. The service does not use medication standing orders. Although no residents were currently self-medicating, processes are in place for this should it be required.</p> <p>Medications are supplied to the facility using the blister pack system. The ACSM advised these packs are checked against the medication chart by a RN on arrival to the service. Documentation related to these checks was sighted. All medications in the medication trolley and stock cupboards were within current use date. A stocktake of all controlled medication is undertaken weekly, and the pharmacy report from their recent six-monthly medicine management review was sighted. Records of the daily check of the medication fridge temperature were sighted, with temperatures being maintained within an appropriate range.</p>

		All aspects of medication management comply with legislative requirements and safe practice guidelines.
<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>Experienced and appropriately qualified staff are responsible for food services within the facility. Both cooks have completed NZQA Unit Standard 167 food safety. The kitchen manager has just been appointed to their role.</p> <p>On inspection, the kitchen was well maintained, clean and tidy. Food storage complied with all current legislation. Food in the fridge and freezers was dated and covered. Cleaning schedules were sighted, and details of their implementation recorded. The daily monitoring of fridge and freezer temperatures was documented, with temperatures remaining within recommended ranges. The kitchen has a current certificate of hygiene issues by the local authority.</p> <p>The kitchen caters for a range of nutritional requirements, including diabetic, puree and soft diets. Specialised crockery, such as lip plate and feeding cups, are available. A six-weekly weekly menu, with summer and winter options, is provided by the organisation. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded on the kitchen whiteboard. Residents are weighed monthly and there was evidence of careful and ongoing monitoring of, and response to alterations in residents' nutritional status.</p> <p>There is one dining area for residents, with two sittings for each meal. Refer also to criterion 1.4.5.</p> <p>Residents reported their enjoyment of meals, and their appreciation of the changes that had been made to enhance their dining room experiences.</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 ACSM advised that if a prospective resident did not meet the entry criteria, or there was currently no vacancy, then either they or the facility manager would work with them and the CC Care Coordination Centre to support them to find appropriate care/placement.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	FA	<p>Residents are assessed by a registered nurse within 24 hours of admission. A short term care plan is developed utilising a range of information provided by the resident/family, the NASC assessment, and any other relevant referral information. Within three weeks of admission a long term care plan is developed integrating the interRAI assessment findings, other relevant clinical and referral information,</p>

gathered and recorded in a timely manner.		<p>and resident/family input. There was evidence in all residents' records reviewed of a comprehensive assessment process which had been completed within required timeframes.</p> <p>Two staff have completed interRAI assessors training, while a third is just completing this training. The ACSM advised that all residents have a current interRAI assessment, and all residents' records reviewed contained a current interRAI assessment.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Residents and families stated they felt included in the development of residents' service delivery plans, and their ongoing evaluation.</p> <p>All of the residents' records reviewed included an individualised and detailed care plan which outlined comprehensive strategies to guide care delivery staff to support the resident's identified needs. This was sighted in all of the resident records reviewed. Plans incorporated the interRAI assessment findings, and generally reflected the support needs of residents, although incorporating the outcomes of specialist health assessments was not consistently achieved.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>There was evidence in all residents' records reviewed of regular, timely and comprehensive ongoing assessment of needs which then informed the provision of care services. Refer also to criterion 1.3.5.3.</p> <p>Registered nurses are on duty 24 hours a day who provide support and guidance for care delivery staff and have completed competency assessments in relation to clinical responsibilities, such as medication administration and syringe driver management. They are supported in their practice by a range of clinical policies and resources and the expertise of the facility manager and the ACSM. Staff also refer to specialist health professionals for additional support and guidance in relation to specific resident needs, such as wound care and palliative care.</p> <p>The doctor expressed confidence in the services provided to residents.</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</p>	<p>FA</p>	<p>The recreation officer, who is onsite for 30 hours weekly, was appointed to their role in the middle of May 2015. They have had three months experience working as a care giver, but have no formal qualifications or experience in their current role. They are being supported by a qualified diversional therapist from a nearby UCG facility and are planning to undertake formal training in the near future.</p> <p>Residents' previous and current interests are assessed on admission and individual activity plans normally completed within three weeks and reviewed six monthly. A number of care plans were not</p>

<p>service.</p>		<p>current at the time the recreation officer commenced employment and a plan is in place to ensure that by 12 June 2016 all plans will be current.</p> <p>Resident activity preferences help inform the development of the facility's activity programme. Activities planned for May/June included entertainment, group discussions, quizzes, housie, craft, church services, exercise, singalong, happy hour and twice-weekly outings in the facility van. Activities are provided on an on-on-one basis and in a group format, with support from several volunteers.</p> <p>Residents expressed their enjoyment of the activities programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>InterRAI reassessments are undertaken at least six monthly. Registered nurses utilise this assessment information to help inform the six-monthly evaluation of resident progress towards identified goals. Evaluations reviewed in the residents' records were detailed and reflected careful consideration of progress. Care plans were evaluated at least six monthly and more frequently if clinically indicated. When residents' progress was different from what was planned, care plans are not always updated, or short term care plans developed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The right of residents to access other health and/or disability providers is maintained. Residents are able to choose who will provide their medical services.</p> <p>If the need for other services is identified, the doctor or a registered nurse sends a referral to seek specialist provider assistance. Residents' records included numerous examples of referrals to specialist health services. The residents/families confirmed on interview that they are kept informed about the referral processes. Support is available to transport and accompany residents to external health-related visits, such as to the dentist or hospital outpatient appointments, as sighted in residents' records and confirmed during interviews with families.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during</p>	<p>FA</p>	<p>The management of waste and storage and handling of chemicals policies and procedures provide clear guidelines/ instructions around the management of all waste and hazardous substances.</p> <p>An external firm is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. In the locked cleaning storage area instructions for safe use was sighted. Cleaning products are all colour coded for ease of identification. The training records confirmed chemical and spill training is completed annually. The cleaner/laundry staff member interviewed was able to detail process and procedures required for the safe use of all products for both</p>

<p>service delivery.</p>		<p>the laundry and cleaning duties. Special masks and gloves are provided in the sluice room, along with the regular supplies, for use with the sluice machine cleaners.</p> <p>Aprons, gloves and masks are provided cleaning storage area and in all areas where personal cares are involved as well as the laundry and cleaning areas. Staff were observed using these throughout the facility as appropriate during the audit.</p> <p>The maintenance person had a locked cupboard where any hazardous substances used in his role are stored.</p> <p>Any incidents are reported and documented, then entered into the GOSH quality management system. Both clinical and non-clinical staff report they are clear about the process for incident reporting in this area.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building warrant of fitness (WOF) was sighted and expires on 10 November 2016. All electrical equipment is checked and calibrated regularly with records kept in a register by the facility maintenance manager. Hot water temperatures are recorded monthly and any variations responded to.</p> <p>The hallways are wide enough to ensure any mobility aids are able to be used easily. All equipment is stored safely. Handrails are installed in all the hallways to assist with safe mobility.</p> <p>The facility is located in a challenging physical environment. While outside areas are able to be accessed from individual rooms currently, this will be made even easier with the installation of the planned threshold ramps. The installation of automated doors at the front entrance would also improve ease of access. The gardens are 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>The number of bathroom facilities are adequate for the number of residents. They are hygienic and well maintained with privacy locks installed. They are all currently a part of a refurbishment and upgrading process which will be ensuring these are fully equipped with appropriate grab rails and relevant assistance equipment to encourage independence where possible. A large bathroom able to accommodate a bed bath as well as a shower is provided. A separate visitor's toilet is located adjacent to the lounge area. All are clearly labelled.</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>	<p>FA</p>	<p>All the residents' rooms are fit for purpose and enable the safe use of any mobility or assistance equipment required. All are kept very clean and tidy with residents and families encouraged to personalise their own environments. The rooms are spacious and residents spoken with expressed satisfaction with their rooms and the facility environment in general.</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>	<p>FA</p>	<p>A comfortable lounge area has a large television and is well set up to use as a relaxation area and as well as an area where a number of activities take place. The dining room has recently undergone a significant change in the ways it operates and its environment. This is the subject of a continuous improvement rating which has resulted in a significant improvement in resident satisfaction at meal times.</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>There are specific laundry and cleaning policies which outline the aims and outcomes expected from the laundry services. The procedures for the treatment and cleaning of soiled laundry are clearly documented with clear definitions of the process for clean and dirty areas. There are internal audit tools for laundry and cleaning services and the most recent audits were reviewed and recorded appropriate effectiveness of both services.</p> <p>The laundry detergents are supplied by an external agency. Product data sheets are displayed in the laundry and cleaning area. Regular training is provided to personnel involved in both laundry and cleaning duties. This is confirmed by relevant staff interviewed. The housekeeping manager is aware of all procedures should a spill occur and she reports all chemicals and cleaning agents are checked and replaced on an as required basis. Machines are serviced regularly. All laundry is sorted into colour coded bags which separates the soiled and dirty linen and personal clothing. Any soiled laundry has been through the sluice room process prior to arrival at the laundry. The process for washing linen is observed and follows the policy requirements. The laundry has the required separation for dirty and clean laundry with well-marked areas for managing that.</p> <p>The standard of cleanliness throughout the facility during the audit was observed as very high with staff consistently using appropriate protective clothing.</p>
<p>Standard 1.4.7: Essential,</p>	<p>FA</p>	<p>There are polices / procedures and guidelines for emergency planning, preparation and response.</p>

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>There is a civil defence plan which has all relevant local information with telephone numbers and addresses for the civil defence centre and emergency response centre, where and how much emergency water is held on site, the location of fire suppression equipment in the facility, the evacuation plan and assembly points. There are disaster planning guides which direct the facility in their preparation for disasters including earthquake, floods, storms, gas leaks and power outages. It also describes the procedures to be followed for fire evacuations and regular practices.</p> <p>The last fire evacuation drill was held in January this year. These are managed by an outside contractor and are held six monthly. The approved evacuation plan was sighted with approval dated 8 June 2001. Monthly testing of the sprinkler system occurs.</p> <p>The emergency supplies are standard for the organisation and are stored in a number of areas around the facility. Four civil defence boxes are regularly checked and updated. Adequate emergency water is stored in individual rooms with larger amounts stored in the nurses' area and outside. Pandemic boxes are also stored in the nurses' station. Emergency food supplies are kept on site. An emergency generator is available if needed and emergency lighting and battery backup facilities are in place. The two health and safety representatives interviewed were aware of all the necessary emergency safety systems and supplies and also provided training to staff as needed.</p> <p>The electronic call system displays the relevant room number in lights in a number of areas around the facility to alert staff as to which resident is requiring attention. During the audit bells were observed to be answered promptly.</p> <p>The quality committee monthly meetings discuss any safety and security incidents reported and they ensure hazards are eliminated or controlled across the facility. Staff training in emergency evacuations is completed regularly and at all orientations. These were sighted as recorded and completed.</p> <p>All windows and doors are locked and checked each night. A contracted security firm does regular checks overnight and these are recorded by the night staff.</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>	<p>FA</p>	<p>All Individual rooms have large opening external windows and most have doors that open onto outside areas. Central heating is installed across the facility in both rooms and the communal areas. Additional heating in rooms is provided with oil heaters if required. Bathrooms have fan heaters. All areas are well ventilated and temperatures during the audit were comfortable. Residents reported no concerns with the heating or ventilation.</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>	<p>FA</p>	<p>Infection control management is guided by a comprehensive infection control manual. The manual includes definitions, procedures, guidelines to identify infections, information for all employees related to accidents, spills, needle stick injury prevention, sharps management and single-use items.</p> <p>The ACSM is currently the designated infection control coordinator, although this role is shortly to be assumed by another registered nurse. Infection control matters, including surveillance results, are reported monthly to the Quality Committee and to the facility manager. Meeting minutes and monthly reports were sighted. The results of the surveillance programme and any other infection control matters are shared with staff via the regular staff meetings and at staff handover meetings. This was confirmed in staff interviews.</p> <p>The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. A sign in the reception area requests anyone who is or has been unwell in the past 48 hours to not enter the facility.</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>	<p>FA</p>	<p>The infection control coordinator, an experienced registered nurse, has only been in this role for approximately one month. They completed infection control training in March (education record sighted) and are supported in their role by a very experienced facility manager. Senior clinical staff at head office are also available as a resource if required, together with the infection control team at CCDHB when additional support/information is required. The coordinator advised that in their infection control capacity they have access to residents' records and diagnostic results to ensure timely treatment and resolution of infections.</p> <p>Another experienced registered nurse will become the infection control coordinator in the near future. The ACSM and the FM confirmed that arrangements are being made for this staff member to have appropriate training to support them in their new role.</p> <p>Protective equipment is freely available to staff, who confirmed the availability of this equipment. The service also maintains a supply of additional equipment in case of an infection outbreak (supplies sighted).</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current</p>	<p>FA</p>	<p>A comprehensive policy/procedure manual, prepared at an organisational level, guides infection prevention and control practices. These documents comply with relevant legislation and current accepted good practices. Care delivery staff were observed using hand-sanitisers on a regular basis and wearing disposable aprons and gloves as appropriate. Housekeeping and kitchen staff were observed to be compliant with generalised infection control practices. Laundry management processes</p>

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.		are consistent with best practice to minimise prevention and control of infection.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ACSM outlined the infection control component of the staff orientation programme. This includes buddying the new staff member with a senior staff member, requiring them to read specific section of the infection control manual, and completing hand washing competencies. Annual infection prevention and control education was provided to staff, as confirmed in staff training records and the annual education plan. This includes six-monthly observation of staff hand washing competency. This education is provided by suitably qualified registered nurses, including the Infection Control Coordinator. The Infection Control Coordinator advised that additional staff education is also provided on an as-required basis, such as if there was an infection outbreak or if there were an increased incidence of resident infections, such as urinary tract infections.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is undertaken of a range of infections, including wounds, urinary tract, respiratory, eye, oral and gastrointestinal infections. Staff complete infection notification forms when an infection is diagnosed. These are collated by the infection control coordinator, and are then entered into the organisation's GOSH database, analysed at an organisational level and benchmarked with other UCG facilities. A report is then supplied back to the facility, including recommendations for further actions as appropriate. The monthly surveillance results are also reported to the facility manager and discussed as part of the quality meeting. Graphs generated from the GOSH database are displayed in the staff room and results discussed at the qualified nurses' meeting and general staff meeting.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use	FA	The organisation has a comprehensive suite of policies and procedures which meet the requirements of the restraint minimisation and safe practice standards with appropriate definitions provided. The restraint coordinator, who has been in the role for three months, provides oversight to the restraint management processes of the facility. In interview she demonstrated a clear understanding of the

<p>of restraint is actively minimised.</p>		<p>organisation's policies and procedures and these clearly guide practice.</p> <p>The policies and procedures emphasise that the use of restraint is a last resort and all alternatives are explored before restraints are used. This is also evident at interview with the restraint coordinator and on review of file records of those residents who have approved restraints and enablers. The use of restraints is minimised as much as possible while still maintaining safety. The facility is committed to working towards a restraint free environment.</p> <p>On the days of audit there were two residents using enablers. In both cases the residents have requested the equipment (bed rails) and a similar process to that followed for the use of restraints is used for enablers. This provides for a robust process which ensures the on-going safety and wellbeing of the resident. In all cases the resident is voluntarily using the equipment and it is included in their care plan.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>There is a restraint approval process and a restraint approval group which is a part of the organisation's quality group. The group is made up of the CSM, the facility manager and the restraint coordinator. The group meets regularly every month as a part of the quality process with a full organisational review and evaluation meeting six monthly. The resident's general practitioner is also a part of any approval and review process.</p> <p>Restraints are used for safety only. Records were reviewed and confirmed that the restraint coordinator, a registered nurse, has accountability and responsibility for restraint processes at Ultimate Care Maupuia. There is a position description for the restraint coordinator which describes the role and responsibilities. The meeting minutes and records on residents' files demonstrated that the restraint coordinator has been undertaking the role as described.</p> <p>On the days of audit there were three residents with approved restraints. It was evident from review of quality meeting minutes and collated data that the overall use of restraints is being carefully monitored and analysed. The organisation's processes are implemented and the approval process is followed.</p> <p>Residents who have approved restraints have all the appropriate approval documentation on their files. Their care plan includes reference to the current approved restraints in use. There is also evidence of family/whanau/EPOA involved in the decision making as is required by the organisation's policies and procedures.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous</p>	<p>FA</p>	<p>The assessment process includes all requirements of this standard. The initial assessment is undertaken by the restraint coordinator or another registered nurse with the restraint coordinator's involvement, and input from the resident's family/whanau/EPOA. The general practitioner is always</p>

<p>assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>involved in the final decision on the safety of the use of the restraint.</p> <p>The assessment process includes consent from the resident's family/whanau or EPOA, whomever is most appropriate. All four residents using restraints at the time of the audit have a current assessment and consent form. All historical information and comments from any referrers are included in the assessment process as are any cultural considerations.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised. At interview with the coordinator, she described how alternatives to restraints are discussed with family/whanau when they request restraints. Time is spent explaining how the resident can be safely supported and alternatives explored before use of a restraint is implemented. Family/whanau interviewed confirmed they are included in decision making.</p> <p>A restraint register is maintained by the restraint coordinator. It is updated every month and reviewed at every restraint approval group meeting. The register for this year was reviewed. It had been maintained throughout this time. Changes on the register reflect changes in need and any resident changes over this time.</p> <p>Staff members interviewed reported that restraints are used as a last resort and only to ensure safety. They receive training in the organisation's policy and procedures and in related topics such as supporting people with challenging behaviours in positive ways. Their understanding is that the use of restraints is to be minimised as much as possible.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The use of restraints for every resident is reviewed monthly with a review including the resident's general practitioner being completed every three months. This includes a updating all the documentation relating the use of the restraint should any changes be required. Feedback is sought from staff involved in the providing care and support to each resident. All changes since the last review are considered with the possibility of removing the restraint if possible.</p> <p>All requirements of this standard are included in the evaluation of restraint use and are documented on each resident's file. This was confirmed on review of files during this audit.</p> <p>When restraints are in use they are monitored frequently to ensure the resident remains safe. The timeframe for monitoring is included in the resident's care plan and monitoring forms record that this occurs as described in residents' plans. The RN on duty is responsible for ensuring all documentation is completed each shift.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint approval group undertake a six monthly review of all restraint use which includes all the requirements of this standard. Additional information is included in the quality committee minutes meeting which has benchmarked data and graphs of restraint use over time with other Ultimate Care Group facilities.</p> <p>The restraint monitoring and quality review documentation was reviewed for the current year and the numbers have remained low. No incidents have been recorded and appropriate training is being completed on a regular basis at orientation and as a part of the annual training programme. The focus remains on working on reducing use of restraint.</p> <p>Interviews with staff members confirmed their understanding of a focus on safety, wellbeing and reducing the use of restraints as much as practicable.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	The ACSM advised that resident’s progress notes are updated every shift, and this was confirmed in all nine clinical files reviewed. In those progress notes, clinical files the names and/or designations of staff making entries into resident progress notes were not consistently legible.	The names and designations of service providers making entries into the residents’ records are not always legible.	The name and designation of service providers making entries into the residents’ records are clear and legible. 180 days
Criterion 1.3.5.3 Service delivery plans demonstrate service integration.	PA Moderate	The service consistently refers residents to specialist health providers, such as the community dietician, psychogeriatric services and speech language therapists when clinically indicated. In four of the nine residents’ records reviewed specialist health assessment had been completed, and a treatment plan advised, but this plan was not then directly incorporated into the resident’s long-term care plan.	There is evidence of timely referrals to and assessments by specialist health services and of multidisciplinary reviews. However agreed changes in treatment are not being integrated into the service delivery planning process.	All treatment changes recommended by specialist health services are incorporated into the resident’s service delivery plan.

				90 days
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA</p> <p>Moderate</p>	<p>Evaluation of residents' progress towards identified goals was detailed and systematic. Wound management evaluations were also detailed. Short term care plans are consistently developed in relation to residents' infections, and the evaluation of wound management was regularly documented.</p> <p>In three of the residents' records, care plans had not been updated when the resident's clinical needs had changed, and a short term care plan had not been developed in relation to an acute clinical event.</p>	<p>Short term care plans are not always developed in response to identified changes in residents' needs and/or the long term care plans are not being updated in response to evaluation and review findings.</p>	<p>Short term care plans are implemented in response to identified changes in residents' needs. Long term care plans are updated to reflect evaluation and review findings.</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 1.4.5.1</p> <p>Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.</p>	CI	<p>The facility had become concerned that the current dining experience was not meeting the needs of the residents, as some of the more independent people were staying in their rooms to eat rather than joining the others. They met with residents, families, visitors and staff and the feedback identified concerns that the layout of the dining room was a little congested, the décor was not appealing and there was a lack of timeliness with getting meals. An action plan was developed which included changes to the décor and seating arrangements, and two dining sittings were initiated. The first one catered for residents who needed assistance at mealtimes and the second sitting a little later was set up for the more independent residents. The cook worked on meal presentation and introduced a number of theme evenings and cultural days to add some interest to the dining experiences for the residents. The changes resulted in an overall increased satisfaction in the resident dining experience and also showcased the improved ambience in the dining room as an attraction for future residents.</p>	<p>A quality initiative was implemented to improve the dining experience for the residents at the facility following concerns that the current dining experience was not meeting the needs of all the residents. Feedback sighted from a residents' survey, families and the local DHB evidenced that this initiative is one that has made a positive difference at the facility.</p>

End of the report.