

Kaylex Care Limited

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:	Kaylex Care Limited	
Premises audited:	Eastcare Residential Home	
Services audited:	Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 10 February 2015	End date: 11 February 2015
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:	45	

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

Eastcare Residential Home provides rest home and specialist dementia level care for up to 49 residents. On the day of audit there were 45 residents.

This certification audit was conducted against the relevant Health and Disability Services Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

The facility manager is an appropriately qualified and experienced registered nurse who is supported by other registered nurses including the director/owner. The quality and risk systems and processes are being well maintained.

There is one area of continuous improvement awarded around the implementation of quality improvement plans which have led to safer and improved services for residents. These include positive outcomes from a falls prevention programme and promotion of an exercise programme, a dementia education programme for families, improvements to all external areas and the interior of the secure dementia units, and increasing food choices and independence for residents.

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.
--	--	--

Staff demonstrate 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 interviewed expressed high satisfaction on how all staff work in a calm and caring manner with respect for each resident.

The service providers reported there were no barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written consents are obtained from the residents' enduring power of attorney (EPOA) or appointed guardians. Signed consent forms were sighted in all residents' files reviewed. Processes are in place for advance care planning and, as medically indicated, resuscitation directives are recorded.

The organisation provides services that reflect current accepted good practice. This was evidenced in the guidelines for general care and the care of residents who are living with dementia. The care staff have completed, or are enrolled in, national unit standards for dementia care. There is regular in-service education and staff access external education that is focused on aged care and best practice.

Linkages with family and the community are encouraged and maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

All standards applicable to this service fully attained with some standards exceeded.

The quality and risk management systems are being improved upon and well maintained. There is regular monitoring of all service areas through internal audits, and monthly collection, collation and analysis of quality data.

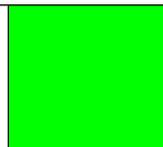
Human resources are managed well according to policy and good employer practices. There is evidence that new staff are recruited in ways that ensure their suitability for the position. Orientation to the facility and its policies and procedures, including emergency systems, is provided to all new staff by senior management and 'on the floor' staff. Staff training is planned and co-ordinated by an allocated registered nurse educator who is employed part time. Education is planned to ensure that staff receive relevant and timely training on subjects related to older people. Training occurs at least monthly through in-service sessions, and through self-directed learning and presentations by external experts. Staff competency assessments and performance appraisals occur regularly.

There are sufficient numbers of care staff and auxiliary staff allocated on all shifts, seven days a week to meet the needs of residents who are assessed as requiring both dementia and rest home level care. There are registered nurses (RNs) on site Monday to Friday and available on call 24 hours a day seven days a week.

All resident files are intergrated and are 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.

The service has policies and processes related to entry into the service.

Services are provided by suitably qualified and trained staff to meet the needs of residents. Residents have an initial nursing assessment and care plan developed by the registered nurse (RN) on admission to the service. The service meets the contractual times frames for the development of the long term care plan. When there are changes in the resident's needs, a short term care plan is implemented to reflect these changes. The care plan evaluations are conducted at least six monthly on all aspects of the care plan.

Residents are reviewed by a GP on admission to the service and at least three monthly, or more frequently to respond to any changing needs of the resident. The provision of services is provided to meet the individual needs of the residents. A team approach to care is provided ensuring continuity of services. Referrals to other health and disability services is planned and coordinated as required. The families interviewed reported that interventions were consistently implemented and that the service managed the residents in a manner that reduces instances of challenging behaviours.

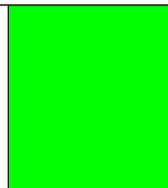
The service has a planned activities programme to meet the recreational needs of the residents with a focus on residents with impaired cognitive function. Residents are encouraged to maintain links with family and the community.

A safe medicine administration system was observed at the time of audit. The service has documented evidence that staff responsible for medicine management are assessed as competent to do so.

Residents' nutritional requirements are met by the service. Residents' likes, dislikes and special diets are catered for, with food available 24 hours a day. The service has a four week, summer/winter rotating menu which is approved by a registered dietitian.

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.

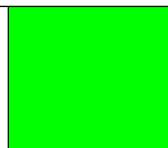
There is a current building warrant of fitness and the buildings, equipment and chattels are being well maintained. There are improvements to external and internal areas since the previous audit and this is recognised in the rating of continued improvement in standard two.

Resident areas (eg, bedrooms and communal living spaces) are spacious, safe and appropriate for the people who are using them.

Essential emergency equipment and systems are known by staff and are being monitored and maintained. Cleaning and laundry processes meet the requirements. Temperatures in the home were comfortable on the days of audit. There is air-conditioning and plenty of opening doors and windows for maximum ventilation.

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.

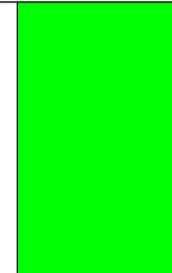


Standards applicable to this service fully attained.

The service has a policy of no restraint except in emergency situations. There were no residents requiring ongoing physical restraint or enablers. Emergency restraint interventions have occurred since the previous audit. Policies and procedures in line with the restraint minimisation and safe practice standard have been followed during these events. Staff education on restraint minimisation is provided during orientation/induction and regularly as part of the in-service education programme.

Infection prevention and control

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



Standards applicable to this service fully attained.

The 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. Infection prevention and control policies and procedures reflect current accepted good practice. Relevant education is provided for staff, and when appropriate, the residents. There is a monthly surveillance programme, where infections are collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings.

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	1	49	0	0	0	0	0
Criteria	1	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The rights policy contains a list of consumer rights that are consistent with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The service policy states the Code is displayed and available to all residents and monitored to ensure the rights of residents are respected. New residents and family are given a copy of the Code on admission and a copy is displayed on the wall in full view for residents, caregivers and visitors. On commencement of employment all staff receive induction orientation training regarding residents' rights and their implementation. The policy meets the intent of this standard.</p> <p>The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. At the time of audit staff were observed to be respecting the residents' rights in a calm manner that de-escalates and redirects the residents with cognitive impairment.</p> <p>Families and residents interviewed reported knowledge of the Code of Rights and stated that the residents were treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are</p>	FA	<p>A detailed informed consent policy ensures informed consent is part of all care plans and contact with families. Every resident has the choice to receive services, refuse services and withdraw consent for services. If a resident is cognitively alert they will decide on their own care and</p>

<p>provided with the information they need to make informed choices and give informed consent.</p>		<p>treatments unless they indicate that they want representation. Informed consent is closely linked with the Residents' Code of Rights and Responsibilities.</p> <p>The residents' files reviewed have consent forms signed by family/whanau or enduring power of attorney (EPOA). The caregivers interviewed demonstrate their ability to provide information that residents required in order for the residents to be actively involved in their care and decision-making. Staff interviewed acknowledged the resident's right to make choices based on information presented to them. Staff also acknowledged the resident's right to withdraw consent and/or refuse treatment, with the staff demonstrating good knowledge on management of challenging behaviours.</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>The family/whanau interviewed reported that they were provided with information regarding access to advocacy services. Family/whānau are encouraged to involve themselves as advocates. Contact details for the Nationwide Health and Disability Advocacy Service are listed in the client information booklet and in the brochure available at the entrances to the service. Related education for staff was conducted as part of the in-service education programme.</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>There are no set visiting hours and family/whānau are encouraged to visit. The family/whanau interviewed reported there were no restrictions to visiting hours. Evidence is seen of residents being supported and encouraged to access community services with visitors or as part of the planned activities programme.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaint management system complies with right 10 of the Code and the requirements of this standard. At the time of this audit there had been four complaints received since the previous audit. None of these were serious or involved the office of the Health and Disability Commissioner or the District Health Board. Review of the complaint documentation and interview with the facility manager showed that the complaint procedures were adhered to, investigations occurred and actions happened in a timely manner which resulted in resolution of the complaint. Interview with the owner, staff, residents and family demonstrated thorough understanding of the complaint process.</p>
<p>Standard 1.1.2: Consumer Rights</p>	FA	<p>The family/whanau that were available for interview report that the Code was explained to them on admission and is part of the admission pack. Those residents who were able to be interviewed</p>

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>reported that they were treated well and are happy with the care given. Nationwide Health and Disability Advocacy Service information is part of the admission pack with brochures available at the entrance as sighted.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The abuse and neglect policy gives clear definitions and guidelines on managing any incidents or suspected incidents of abuse or neglect of residents. A dignity and privacy policy requires the visual privacy and personal space of residents to be respected and observed at all times and staff will facilitate the use of private space for interaction with residents.</p> <p>The family/whanau members interviewed reported that their relative is treated in a manner that shows regard to the resident's dignity, privacy and independence. The caregivers interviewed reported that in-service education relating to behaviour management programmes assists them in their care of residents with dementia.</p> <p>The residents' files reviewed indicate that residents receive services that are responsive to their needs, values and cultural beliefs, religion and ethnicity. The family/whanau interviewed report high satisfaction with the way that the service meets the needs of their relatives.</p> <p>As observed on the day of audit and confirmed with review of the residents' files, residents received services in the least restrictive manner to meet the independence and wishes of the residents. The family/whanau and the one general practitioner (GP) interviewed expressed no concerns in relation to abuse or neglect. The family members reported that the staff were very good at intervening with any potential aggressive behaviour with residents.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>A comprehensive Maori health plan recognises the principals of the Treaty of Waitangi. It aims to ensure a Maori Health Strategy based upon partnership, participation and protection for Maori working alongside whanau developing and providing culturally appropriate services.</p> <p>The nurse manager/RN reported that there are no barriers to Maori accessing the service. The caregivers interviewed demonstrated good understanding of services that are commensurate with the needs of the Maori resident and importance of whanau.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	<p>FA</p>	<p>The organisation's cultural safety policy is detailed and requires staff to ensure that the admission nursing care assessment for care planning, will identify a resident's individual values, beliefs and culture. Staff receive annual training in cultural awareness across a number of cultures.</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>The residents' files reviewed demonstrated consultation with the family about the resident's individual values and beliefs. The family/whanau interviewed reported they were consulted with the assessment and care plan development. The caregivers interviewed demonstrated good knowledge on respecting residents' culture, values and beliefs.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff files reviewed have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. The family/whanau and residents interviewed reported they were happy with the care provided. The family expressed no concerns with breaches in professional boundaries, and all report high satisfaction with the caring, calming and patient manner of the staff.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice was observed, promoting and encouraging good practice. This is also evidenced in interviews with the nurse manager/RN and caregivers. The gerontological nurse specialist visits residents as required to consult regarding residents who are referred for additional care advice. The service utilises the care guides from the DHB. All of the caregivers have completed or are enrolled in education specific to specialist dementia care.</p> <p>There is regular in-service education and staff access external education that is focused on aged care and best practice. The caregivers interviewed reported they were very satisfied with the relevance of the education provided, especially around the management of challenging behaviours.</p> <p>The family/whanau and residents interviewed expressed high satisfaction with the care delivered. The GP reports that an excellent level of care is provided at the service and the care staff demonstrate good clinical skills.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The service promotes an environment that optimises communication through the use of interpreter services as required and staff education related to appropriate communication methods. The service has not required access to interpreting services. Policies and procedures are in place to access interpreter services where required, as confirmed at interview with the clinical manager.</p> <p>The family/whanau interviewed confirmed they were kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure is documented in the family communication sheets, on the accident/incident form and in the residents' progress notes.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>On the days of audit there were 15 residents requiring rest home level care and 30 residents requiring dementia level care. (That is, 15 residents in two separate secure dementia units).</p> <p>The directors/governing body continue to receive monthly reports from the facility manager about service delivery, building maintenance and chattels, improvement projects, financial issues, compliments, complaints, audit outcomes and information from networking groups. There is also weekly reporting on bed states and fortnightly 'skype' with the owners and the other two facilities in the group.</p> <p>The service has a clearly defined scope, direction and goals documented in the service marketing literature and the current (2015) business plan and quality and risk plan.</p> <p>Interview and review of personnel records show that the facility manager who has been in the role for two years, has extensive experience nursing in aged care and has completed business management and leadership training. The manager attends regular nursing/clinical education and study days in subjects related to care of older people and in relation to managing a care facility. All managers and RNs have completed training in 'interRAI'. The manager continues to attend regular local provider forums for peer support and DHB forums.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Planned or unexpected absences of the facility manager have been covered by the owner who is a RN with a practising certificate and current knowledge of the residents and services. Interview with the owner, the facility manager, other staff, families and residents reveal that this arrangement is suitable, efficient and effective.</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>	CI	<p>The quality and risk management system continues to be integrated with service delivery and reflects continuous quality improvement. All long term staff understand their role in relation to the system.</p> <p>The service continues to use a standardised quality system of policies and processes. Document review of policies and forms confirms these are current and modified at least every two years in a controlled and informed way across the group.</p> <p>Quality monitoring includes regular checks and audits of service delivery and the collection, reporting and benchmarking of quality data. The facility manager has amended the approach to</p>

		<p>doing monthly trend reports reviews and collates all reported incidents and accidents, medicine errors and infections. This information is discussed at weekly management meetings, and trends are presented to the quality and risk committee.</p> <p>Interview with the business owner, the facility manager and review of the quality data revealed that the data is analysed and benchmarked against the two other facilities in the group to determine performance.</p> <p>The service is rated continuous improvement for the positive outcomes achieved by the implementation of quality improvement plans which have improved service delivery and residents' welfare. These include positive outcomes from a falls prevention plan in 2013, a promotion of exercise programme in 2014 and promotion of a healthy eating programme in place for 2015-2016. Other improvements are providing more hydration to residents during the summer months, providing choice and independence to residents at breakfast, changes to the internal and external areas, a new protocol for administering as needed pain relief, a recent focus on educating and supporting families to understand Enduring Power of Attorney matters, and the introduction of a Dementia Champs education programme.</p> <p>All business risks are monitored by the directors. Occupational health and safety risks continue to be managed by two designated health and safety officers who support staff understand and adhere to procedures.</p> <p>Review of the hazard register confirms that new hazards are reported as they are identified. Environmental audits for safety are conducted regularly and reactive facility maintenance occurs. Chemical safety data sheets are located where hazardous chemicals are stored. Clinical risks are identified in residents' service delivery plans.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Interviews with staff, the facility manager and the owner about the accident/incident reporting system and a sample of reports confirms a managed process of reporting, recording, investigation and review with recommendations to prevent recurrence.</p> <p>Observations confirm that incidents are discussed at shift handover, and trending data is displayed in the staff room. Each resident's file contains a summary of incidents which facilitates a ready review of risks.</p> <p>The directors/owners and the facility manager are responsible for essential notification and reporting and they were conversant with the statutory and regulatory obligations. The provider followed due process by notifying the DHB of a sentinel event in October 2014.</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>Interviews with the facility manager, director/owner and staff and review of personnel records, confirmed that recruitment for new staff adheres to best known employment processes (eg, formal interview, verification of qualifications, contacting referees and carrying out police checks before confirming an employment agreement). The service continues to have a policy that people with a criminal record will not be employed.</p> <p>Review of personnel records showed that the registered nurses and enrolled nurses have current practising certificates, individual employment agreements are signed and include a trial 90 day period, and that each role has a job description.</p> <p>Interview with the nurse/education co-ordinator, facility manager and care staff confirmed that staff training in the care of older people is regular and ongoing. The nurse educator has recently conducted a gap analysis of staff training and is monitoring each staff member's progress with their education goals. There is a focus on 'growing' all healthcare assistants by supporting them to complete specific aged care education (ACE).</p> <p>Documents sighted confirm that care staff and the activities staff maintain first aid certificates and competency in medicines administration. All care staff are enrolled in or have completed the National Certificate in Health, Disability and Age Care or equivalent and the NZQA unit standards in dementia care. There are identified compulsory topics that must be attended at least annually, such as fire drill evacuations, manual handling, medicines, civil defence and emergency preparedness. Fire drills occur in June and December. Other training subjects regularly include restraint and managing challenging behaviour, falls prevention and manual handling, infection prevention and control including wound management, hand washing, urinary incontinence and taking specimens, managing multi-resistant organisms, palliative care, abuse and neglect, cultural safety, privacy, resuscitation and chemical safety.</p> <p>The service has recently focused on providing a specialist dementia education programme (Dementia Champs) to staff and families.</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>Rosters sighted and interview with the facility manager confirms there is an appropriate numbers of skilled and experienced staff on all shifts for the current number of residents (ie, 30 dementia and 15 rest home level care residents) and to meet the minimum requirements of the provider's agreement with the district health board (ARC contract).</p> <p>There is a RN on site Monday to Friday. Two enrolled nurses (ENs) are on site morning and afternoon shift. A RN is rostered on call after hours seven days a week. Two healthcare assistants, one of whom is a senior assistant, are rostered on in each of the dementia units every morning and afternoon with an additional short shift person. There is one healthcare assistant allocated to rest</p>

		<p>home residents each morning and afternoon shift. There are four staff one of whom is a senior healthcare assistant on each night. An additional activities person has been employed since the previous audit so there is now an activities co-ordinator and two assistants on site Monday to Friday during the day and the evenings.</p> <p>The service has introduced changes to the rosters so care staff work a maximum of four days before having two days off. This is aimed at reducing staff stress and tiredness.</p> <p>Auxiliary staff (eg, cooks, cleaners and laundry staff) are allocated sufficient hours to complete their duties. A maintenance person is employed fulltime. Only care staff who have completed, or are in the process of completing qualifications in dementia care, are rostered to work in the dementia units. This is confirmed by sighting a list of all care staff with dates they have completed NZQA unit standards 23920-23923.</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>Residents' information is stored securely and was not on public display. The clinical notes area has a locked door and files cannot be accessed through the window. The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all resident's information sighted. Clinical notes reviewed were current and accessible to all clinical staff in an integrated file. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and the doctor when he visits.</p> <p>The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, national health index number (NHI), the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers are all completed as sighted in residents' files reviewed.</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 service has an admission/enquiry form that records the pre-admission information. An enquiry folder holds a record of the enquiries. The resident admission agreement is based on the Aged Care Association agreement which is individualised to the service. The residents' records reviewed have signed admission agreements by the EPOA or resident. The entry criteria sighted and the service's website clearly identifies that the service provides secure specialist dementia care and rest home. Vacancies are updated daily through Eldernet.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and</p>	FA	<p>Risks are identified prior to planned discharges as confirmed by interview with the RN. A transfer form is used that identified risks. There is open communication between the service and family/whānau related to all aspects of care, including exit, discharge or transfer. If there are any</p>

<p>coordinated transition, exit, discharge, or transfer from services.</p>		<p>specific requests or concerns that the family or resident want discussed, these are noted on the transfer form. The discharge form and care plan summary is provided that covers all aspects of care provision and intervention requirements, including any known risks or concerns. 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 also accompany the resident if they are transferred to hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, the process should an error occur as well as definitions for 'over the counter' medications that may be required by residents.</p> <p>Medicines for residents are received from 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 locked medicine trolleys in the store room. Medicines that require refrigeration are stored in a sealed box in a separate area in a fridge in the kitchen.</p> <p>The medicine charts reviewed were reviewed by the GP at last three monthly, with this review recorded on the medicine chart. All prescriptions sighted contain the date, medicine name, dose and time of administration. All medicine charts had each medicine individually prescribed. There was a specimen signature register maintained for all staff who administered medicines. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident.</p> <p>There were documented competencies sighted for the staff (RN, EN and caregivers) designated as responsible for medicine management. The caregiver administering medicines at the time of audit demonstrated competency related to medicine management.</p> <p>Self-administration of medicines is not suitable or appropriate for residents living in the dementia unit and no residents in the rest home administer their own medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The kitchen and food handling policy states the food handling areas and practices will meet the requirements of the Food Act 1981. It includes guidelines for cleaning with a separate cleaning schedule, temperature requirements, hygiene standards for staff, purchasing of food, checking, storage and waste handling. Regular monitoring and surveillance of the food preparation and hygiene is carried out.</p> <p>The nutrition and food management is undertaken by an external company. The menu is managed by this company and is a four week rotating menu with summer and winter variations. The menu</p>

		<p>has been reviewed by a dietitian. Where there is unintentional weight loss, the resident is referred for a dietitian review; this is seen in the residents' files reviewed.</p> <p>A nutritional profile is completed for each resident by the EN or RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. There is food and nutritional snacks available 24 hours a day. The family/whānau and residents reported that they are satisfied with the food and fluid services.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complies with current legislation and guidelines. Fridge and freezer recordings were observed daily and recorded at least weekly, with the recordings sighted meeting food safe requirements. The kitchen staff have undertaken food safety management education appropriate to service delivery.</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 nurse manager interviewed reports that the service does not refuse referral if the resident has a suitable NASC assessment for dementia level 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. The nurse manager reports that entry has not been declined where a resident has an appropriate assessment for secure specialist dementia care and there is a bed available.</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, this may also involve the crisis team. 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 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The service uses some of the organisation's paper based assessment tools to complement the interRAI assessment. All assessment tools sighted were appropriate to the dementia and rest home care provided. Initial assessment includes falls, skin integrity, challenging behaviour, nutritional needs, continence, communication and pain. Assessments are undertaken by enrolled nurses and overseen by a RN.</p> <p>The residents' files reviewed have initial assessments that includes identifying behaviour particular to the resident. The files reviewed have challenging behaviours identified in the initial or ongoing care review, a specialised behaviour assessment is utilised. The behaviour assessments sighted included the triggers, description of the behaviour, contributing factors and solutions/de-escalation techniques.</p>

		<p>The residents' files reviewed have assessment information that is obtained from external health providers and, where applicable, the resident's family or nominated representative.</p> <p>The service has a continence assessment and management procedure, wound care management procedures, wound care protocols and behaviour management processes, which include seeking expert assistance, such as, mental health services, as required. Where a need is identified, interventions for this are recorded on the care plan. All of the files reviewed have falls risk assessments and pressure risk assessments.</p> <p>The family/whanau interviewed report the residents receive excellent care that meets their relatives' needs.</p>
<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 residents' files reviewed had care plans that address the resident's current abilities, level of independence, identified needs/deficits, and takes into account the resident's habits, routines and idiosyncrasies. The strategies for minimising episodes of challenging behaviours are based on assessment, prevention and de-escalation techniques that are effective for the resident and are evidenced in resident files reviewed. The caregivers interviewed demonstrate knowledge on the management of challenging behaviours.</p> <p>The care plans and diversional therapy plans sighted identified the resident's individual diversional, motivational and recreational requirements, with documented evidence of how these are managed over a 24 hour period. The files reviewed demonstrate integration, with one clinical file that has input from care, activities, medical and allied health services. The ENs and caregivers interviewed reported they received adequate information to assist the continuity of care. The handover observed includes updates of all residents.</p> <p>The family/whanau and the GP report a high level of satisfaction 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>As observed on the day of audit and from review of the care plans, support and care is flexible and individualised and focussed on the promotion of quality of life. The RN, EN and caregivers demonstrated good knowledge and skill in minimising the need for restrictive practices through the management of challenging behaviour and redirection of residents who wander. The residents' files reviewed showed evidence of consultation and involvement of the family. The family/whanau report that the service 'excels' at providing a supportive relationship with the resident that reduces anxiety and maintains a sense of trust, security and self-worth. The residents interviewed report satisfaction with the care and services provided.</p>

		<p>The service had adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed record interventions that are consistent with assessed needs and desired goals. Observations on the day of audit indicate residents are receiving care that is consistent with their needs. The ENs and caregivers interviewed report that the care plans are accurate and up to date to reflect the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The weekly activities plan, which was sighted, was developed based on the resident's needs, interests, skill and strengths. The caregivers assist with the planned activities seven days a week, with the programme being developed by the senior activity coordinator. The programme is reviewed and evaluated at least six monthly.</p> <p>The sighted activities programme covers cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities that focus on sensory activities and reminiscing. The activity coordinators interviewed report they try to utilise residents' interests and long term memories. They gauge the level of interest in activities as they are occurring and have the flexibility to change activities based on the resident's response.</p> <p>The service provides easy access to outside courtyard areas that enable the residents to wander safely. There are tactile objects and plants in the outside areas.</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.</p> <p>A daily activities attendance sheet is maintained and reviewed at the end of each month to assess the enjoyment and interest of the residents. The goals are updated and evaluated in each resident's file six monthly. The participation in activities is recorded on a daily basis. Where possible residents' independence is encouraged to maintain links with family and community groups. Families are encouraged to attend activities. Families take their relative to religious services as appropriate and the service has a chaplain that visits.</p> <p>The families/whanau report that their relatives enjoy the range and variety of planned activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' files reviewed had a documented evaluation that was conducted within the past six months covering all of the issues in the care plan. These evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the desired outcomes.</p>

		<p>If a resident was not responding to the services/interventions being delivered, or their health status changes, then this is discussed with their GP. Residents' changing needs were clearly described in care plans reviewed. Short term care plans were sighted for wound care, pain, infections, changes in mobility, changes in food and fluid intake and skin care. These processes were clearly documented on the short term care plan, medical and nursing assessments and the resident's progress notes. The ENs and caregivers interviewed demonstrated good knowledge of short term care plans and report that these are identified at handover.</p> <p>The family/whanau reported that they can consult with the 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>Residents are provided with options if required to access other health and disability services (eg, public or private). There is one GP who visits the service weekly, although residents are able to maintain their own GP if they wish. The EN or the GP arranged for any referral to specialist medical services when necessary. The GP and RN interviewed report that referral services responded promptly to referrals sent. Records of the process are maintained as confirmed in files reviewed, which included referrals and consultations with the mental health services, general medicine, psychiatrist, radiology, gerontological nurse specialist, podiatry and dietitian. The GP interviewed reports that appropriate referrals to other health and disability services are well managed at the service.</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 clearly described policies and procedures for the safe and appropriate disposal of waste, infectious or hazardous substances which comply with local government and legislative requirements and the requirements of this standard and the ARC contract.</p> <p>Visual inspection on the days of audit revealed that chemicals were stored securely and that there is safe disposal of body waste and contaminated or potentially infectious products. There is a sluice room in each of three designated wings and these are maintained as clean and functional. Personal protective equipment is available and seen to be used on the days of audit.</p> <p>Staff interviews demonstrates knowledge and understanding of safety issues around managing waste and hazardous substances. Staff are provided with ongoing information, education and support by the organisation and external suppliers.</p>
Standard 1.4.2: Facility Specifications	FA	The building is well maintained, in good repair and fit for purpose. There is a current building

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>warrant of fitness.</p> <p>Interview with the maintenance person, review of records and observations on the days of audit show that electrical testing and tagging is completed by a certified electrician annually, most recently in December 2014. All fire safety equipment is checked monthly. Calibrations of scales and medical equipment occurs annually. The two hoists on site are checked regularly for safety. The facility's van has a current warrant of fitness and registration.'</p> <p>There have been upgrades to all external and internal areas which benefit residents. All five garden areas are safe and provide intellectual stimulation and interest by their 'themes' (eg, a beachside bach, gardening shed and laundry area, outside gym). Fences, gates and internal service doors are disguised to minimise their accessibility.</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 toilet/bathing/shower facilities are more than adequate for the number of residents. Hot water monitoring is occurring regularly and temperatures are well within safe limits of below 45 degrees. There have been no issues with maintaining consumer privacy when attending to personal hygiene needs. Toilet and bathroom doors in the secure wings are now painted a solid blue with images of toilets and baths to make these readily distinguishable to residents.</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 rooms have a single occupant in them. The rooms are spacious, contain a bed and easy chair, wardrobe and dressing table. There is enough room for the resident to move around safely with or without a mobility aid. The service meets the requirement of the ARC contract and this standard.</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>Each wing has its own lounge and dining room and these are located within easy walking distance from the resident's bedrooms.</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 sufficient numbers and hours of work dedicated to cleaning and laundry staff. The service continues to conduct regular reviews and internal audits of cleaning and laundry services to ensure these are effective and the best they can be, as confirmed by interview with the director, the facility manager, staff and observations on the day of audit.</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>The service has experience in and a reputation locally for safely managing residents who require more supervision.</p> <p>Sensor beams are now installed in the bedrooms of residents who are identified as at risk of wandering and falls. These are proving to be more reliable than sensor mats for alerting staff.</p> <p>Fire drills are conducted six monthly.</p> <p>There are clearly documented emergency plans, and emergency and security systems are well established and known by staff. There is an approved fire evacuation scheme and records show that fire drills have occurred at six monthly intervals with all staff attending. Staff receive extensive information on emergency procedures at orientation and there is ongoing training about civil defence processes and keeping residents safe during emergencies. Review of staff training records and rosters and interview with the owner and the facility manager show there is a registered nurse on call twenty-four hours a day, seven days a week, and that all staff have current first aid certificates.</p> <p>Interview with the maintenance/health and safety officer and inspection of the emergency/civil defence stores confirms there is sufficient stock of water, food, equipment and essential supplies in the event of a natural disaster or power outage. The facility has back up lighting. The call bell system was observed to be functional during the onsite audit and residents and families interviewed confirm that staff respond to call bells in a timely ways. The provider meets the requirement of ARC contract.</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</p>	<p>FA</p>	<p>Visual inspection of resident areas revealed sufficiently sized windows and opening doors for ventilation. Temperatures in all areas are moderated by heat pumps/air conditioners in all communal areas. There are large opening doors and windows in all areas of the home and electric heaters in resident's bedrooms.</p>

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 which was reviewed annually. The infection control programme minimises the risk of infections to residents, staff and anyone else visiting the facility.</p> <p>The infection control co-ordinator is the facility manager who is an RN and this role is shared with the full time RN. The infection control position description has clear guidelines for the accountability and responsibility in the infection control manual. The infection control co-ordinator monitors for infections, 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 a standing agenda item in the staff meetings. If there is an infectious outbreak this is reported immediately to staff, management, and where required, to the DHB and public health departments.</p> <p>The infection control committee meets every three months and reports back to the quality and risk committee who also meet every three months. Infection prevention issues are reported at staff meetings. The sighted agenda and minutes for the management meeting contains the infection surveillance control data, rate, and interventions. The infection control co-ordinator and GP interviewed reported that the staff have good assessment skills in the early identification of suspected infections. Residents with infections were reported to staff at handover, have short term care plans and documentation in the progress notes.</p> <p>A process was 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 by notices at entrances. When outbreaks are identified in the community, notices are placed at the entrance 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 throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are encouraged to stay in their rooms if required, though the infection control coordinator reports that this can be difficult at times with residents with cognitive impairment.</p> <p>The RN and caregivers interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing and use of PPE.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical,</p>	FA	<p>The RN has the role of infection prevention and control co-ordinator. The infection control committee is part of the quality and risk committee. External specialist advice on infection prevention and control issues is available, if and when required, from the DHB infection control nurse specialist, the diagnostic service, GP, pharmacist and the Ministry of Health. The infection</p>

<p>and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>control co-ordinator has attended courses in infection prevention and control through the in-service education programme and updates from the DHB. The EN and caregivers interviewed demonstrated good knowledge of infection prevention and control.</p>
<p>Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>An infection control policy sets out the expectations the organisation will use to minimise infections. This is supported by an infection control manual and a large suite of policies and procedures that deal with specific areas, including antibiotic use, MRSA screening, bandaging, wound management, blood and body spills, cleaning disinfection and sterilisation, laundry and standard precautions. They are easily understood and appropriate for services requirements.</p> <p>Observations at the onsite audit identified the implementation of infection prevention and control procedures. Staff demonstrated safe and appropriate infection prevention and control practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection control education is included in orientation and as part of the ongoing in-service education sighted on the provider's calendar. The infection prevention and control education is provided by the infection control co-ordinator and external specialists as required. The service accesses specialist advice through the DHB. The infection control co-ordinator demonstrated knowledge of current accepted good practice in infection prevention and control. Recent infection prevention and control education has been conducted.</p> <p>The ENs and caregivers interviewed demonstrated good knowledge of infection prevention and control. Resident education is conducted as required. The infection control coordinator reported that if the resident has cognitive impairment, education can be difficult, though during personal care delivery residents are prompted with infection control measures, such as hand washing after toileting.</p>
<p>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</p>	<p>FA</p>	<p>The infection control surveillance that is undertaken is appropriate to the size and complexity for a dementia and rest home service as shown in the infection control programme. All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring was clearly described in the quality plan and management meetings, to describe actions taken to ensure residents' safety.</p> <p>There is a monthly infection surveillance report. The service monitors urinary tract infections (UTIs),</p>

programme.		eye infections, and upper and lower respiratory tract infections, wound infections, multi-resistant organisms, diarrhoea and vomiting and other infections. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease and actions taken to reduce infections. The analysis includes the feedback that is provided to staff.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service had no restraint or enablers in use at the time of this audit and it has always taken the approach of using alternatives to restraint. This is made clear in the organisation's restraint minimisation and safe practice policies and associated procedures. The policy meets the required Health and Disability Services Standards and identifies how NZS 8134.2.2 is met if restraint is required. The definition of an enabler is congruent with the definition in NZS 8134.0.</p> <p>There have been three emergency restraint events since the previous audit in February and March 2014. Two events are related to the same resident whose ongoing confusion, agitation and aggressive behaviour posed a significant risk to staff and the resident. The challenging behaviour was managed using de-escalation, clearing the areas and safe holding until assistance arrived. The resident continued to be assessed by the DHB older person's service, and when all treatment interventions had been tried the person was transferred to another facility. The management of these events was reviewed and the residents were re-evaluated by external clinicians in an appropriate and timely way and different approaches were trialled. The review of each restraint episode did not result in the service changing its processes or philosophy as it was agreed that actions taken were appropriate and safe at the time.</p> <p>Training records and interviews show that all staff compulsorily attend at least one education session on restraint and management of challenging behaviour and use of de-escalation each year. All new staff are provided with information about the restraint policy, philosophy and approach during their orientation.</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</p>	FA	<p>The RN/facility manager, full time RN and the RN educator are all nominated restraint co-ordinators. The role and responsibilities are clearly described in the co-ordinator position description.</p> <p>Review of policy and other documents and interviews, confirms that the only type of restraint approved is 'one off' emergency restraint interventions. There have been three emergency restraint events in February and March 2014.</p> <p>Training records and interviews show that all staff compulsorily attend at least one education session on restraint and management of challenging behaviour and use of de-escalation each year.</p>

providers and others.		All new staff are provided with information about the restraint policy, philosophy and approach during their orientation.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	There was evidence in the care records and incident reports reviewed on site to show that risks were considered before applying the restraint intervention. All efforts were made to determine underlying causes and that both residents continued to be reassessed by the RN restraint co-ordinators and the visiting DHB clinical team. The records and staff interviewed confirm that a variety of different approaches were tried to minimise and prevent unwanted behaviour.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Review of the service documents which included resident care records, incident reports and meeting minutes and interviews with staff and family confirmed on audit day that the emergency restraint events were only used as a last resort after all other alternatives had been attempted. There was appropriate intervention recorded and all events were sufficiently documented in detail and corroborated by investigations. A restraint register was in place which contains accurately recorded details of events.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Documents, including resident care records, incident reports and meeting minutes and staff interviews confirm that each restraint episode was appropriately evaluated and reviewed. The management of the residents involved was evaluated immediately and reassessment was conducted by external clinicians in an appropriate and timely way. The service provider trialed different approaches to minimise unwanted behaviour, maintained ongoing communication with families, and continued to support staff. The service provider has complied with the requirements of this standard.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Meeting minutes and interview with three restraint co-ordinators confirmed that there has been a thorough review of each emergency restraint event including a debrief with all the staff involved. The records confirm that there was ongoing communication with the families of the two residents concerned. The restraint committee continue to meet at least every three months, or sooner when required for quality review which includes reviewing the care and treatment of residents with challenging behaviour and any events related to this, monitoring how staff manage the events, and review of staff training needs. Monitoring and quality review has not resulted in any significant changes to the processes in place or the service philosophy as it was agreed that actions taken

		were appropriate and safe at the time.
--	--	--

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	CI	<p>Click here to enter text</p>	<p>The service is rated as continuous inprovement (CI) for the positive outcomes achieved by implementation of quality improvement programmes. There is detailed data from a falls prevention plan and programme which was initiated in 2013. Discussion with the facility manager, review of incidents and the programme data, showed that the actions carried out (eg, increased education and information to staff and families, purchase of non-slip socks, installation of motion sensors in bedrooms and night lights in hallways and changes to staffing) resulted in a reduction of the number of residents’ falls. There is a correlating decrease in the number of fractures since the previous audit. All residents receive Vitamin D therapy and staff ensure that all high risk falls residents wear hip protectors. Other successful quality improvement plans include last year’s promotion of an exercise programme which has widened choices and increased opportunities for residents to exercise daily. Eastcare now has its own gym, with all residents engaging in morning walks and group exercise every day and some residents attending swimming and a walking group at a sports arena. This initiate is ongoing.</p> <p>There is promotion of a healthy eating programme for 2015-2016 which aims to reduce the body mass index (BMI) of residents who are above recommended levels.</p> <p>Other initiatives designed to improve resident’s welfare are:</p>

			<ul style="list-style-type: none"> - the introduction of an additional drink round and ice block in the afternoon for extra hydration during hot days. - the promotion of choice and independence by offering residents a range of cereals, fruit and toast condiments at breakfast. - changes to internal and external areas which include five theme gardens, removal of mirrors in communal areas in the dementia wings, repainting of toilet and bathroom doors to clearly distinguish these as ablution rooms, and disguising exit and service area doors to minimise curiosity. - a new protocol for administering as needed pain relief which involves completing a pain assessment and reporting the result to the on call registered nurse when seeking approval to administer medicines. - a recent focus on educating and supporting families to understand Enduring Power of Attorney matters; and - the introduction of a Dementia Champs programme which provides extensive education to families and staff. This has produced positive and grateful feedback from families who say they now better understand the behaviour of their loved ones.
--	--	--	---

End of the report.