

The Ultimate Care Group Limited - Bishop Selwyn Lifecare

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 Bishop Selwyn
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 August 2016 End date: 25 August 2016
Proposed changes to current services (if any):	Ultimate Care Bishop Selwyn is applying to have approval for a couple who require subsidised care to receive this in a studio unit.
Total beds occupied across all premises included in the audit on the first day of the audit:	69



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

Bishop Selwyn provides rest home, hospital medical and hospital geriatric services for up to 78 residents at its facility in central Christchurch. The facility is operated by the Ultimate Care Group Ltd.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the Canterbury District Health Board. The audit process included interviews with residents of the facility and their family members, interviews with staff members, the facility manager and clinical services manager, and review of documents and clinical records.

The facility has studio units for which residents purchase an occupational right agreement (ORA). The provider already has approval for subsidised care in the studio units. Ultimate Care Group is seeking to confirm that couples who have an ORA and require subsidised care can do so while remaining in their unit.

There are no areas requiring improvement identified during this audit. There are three areas of particular strength identified (continuous improvement) in relation to a training initiative, the reduction of admissions to public hospital and increasing residents mobility and independence.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff have received ongoing education on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).

There were no residents at the facility on the days of audit that identify as Maori. Services are planned to respect the individual culture, values and beliefs of the residents.

Staff communicate effectively with residents and their family. Residents, family members and external health providers interviewed, stated that communication is excellent at this service. There was evidence that residents, families and other parties are provided with full and frank information in accordance with the principles of open disclosure. Appropriate written consents have been obtained.

The facility manager responds to all complaints and ensures that this occurs in a timely way. A register is maintained and on the days of the audit this was current and up to date. Residents and family members are able to access complaint forms easily and staff members are trained in how to respond to and support this to occur.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Ultimate Care Group is a privately owned organisation. There is a governing body with an executive management team based at their national support office. Senior managers have operational oversight of all facilities including Ultimate Care Bishop Selwyn through an operational and clinical management structure. There is an annual business and quality and risk management plan. This references the organisation's vision, mission and values.

The facility manager has extensive clinical nursing and management experience. She has overall responsibility for the facility. She is assisted by an experienced clinical services manager who is responsible for the nursing services.

The Group has a documented quality management system which is implemented at Bishop Selwyn. This includes processes for management and control of documents, internal audits, collation and analysis of adverse events, corrective action planning and risk management.

There are procedures for human resources management and these are also followed. Personnel files were sampled and this confirmed that a safe recruitment and selection process occurs. Employed and contracted health and allied health staff have their practising certificates and/or professional registrations validated and monitored. There is orientation training to ensure all staff understand the requirements of their roles, and ongoing training for all staff. The facility has a sufficient number of registered nurses who are trained and competent in completing the interRAI assessments.

The organisation has a documented rationale for the safe allocation of staff across the facility that is based on best practice. Staff members interviewed reported that there are adequate numbers of staff on duty to meet the needs of residents.

Records reviewed are complete and current and include identifiable signatures and staff identification. All current and archived records are secured.

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.

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

Entry criteria for the service is documented and available for any person and referral agency. The facility manager or clinical services manager discuss any prospective referral with the referral agency to ensure admission is appropriate. If entry to the service is declined, a record is maintained.

Residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. Each stage of service provision is undertaken by suitably qualified/experienced staff competent to perform the function.

The processes for assessment, planning, provision, review, and exit are provided within time frames that safely meet the needs of the resident and contractual requirements. The interRAI assessment tool has been fully implemented. Care plans reviewed described the required support and/or intervention to achieve the desired outcomes. The provision of services and interventions is consistent with, and contributes to, meeting the residents' needs. There is evidence that the organisation implements interventions and initiatives that improve resident outcomes, reduces falls and acute hospital admissions.

Evaluation of care is consistently documented at least six monthly.

Support for access, or referral, to other health and/or disability service providers is appropriately facilitated.

The service provides an activities programme which reflects residents' preferences. The activities are planned and provided to develop and maintain skills and interests that are meaningful to the residents.

A medication management system is in place that meets all legislative and guideline requirements. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage.

The menu has been reviewed by a dietitian as suitable for the older person living in long term care. Residents and family reported satisfaction with the meals and choices provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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All buildings plant and equipment complies with legislation. There is a current building warrant of fitness for the facility and all ongoing checks of building systems occur.

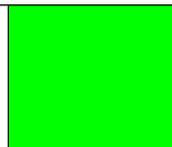
Bishop Selwyn has a mix of studio apartments, and two different sized rooms. Studios are only utilised under an occupational right agreement. The studios are large enough to accommodate a couple where it is their wish to share a room. All rooms have large external facing windows which open to allow fresh air and sunlight. There is an electrical heating with a mix of wall mounted, ceiling and underfloor and heaters.

There is an appropriate call bell system and security arrangements. Fire evacuation practices occur regularly and there are fire suppression systems within the building and additional equipment available if needed. Emergency preparedness plans are in place and regular checks are completed.

Personal protective equipment is available and worn by staff when. All chemicals and equipment are used safely and stored securely when not in use. Staff members follow guidelines for effective cleaning and laundry, which is all done on site. There is monitoring to evaluate the effectiveness of cleaning and laundry services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

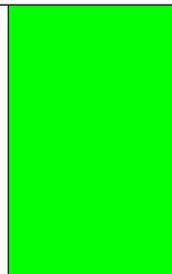


Standards applicable to this service fully attained.

There is a philosophy of no restraint use which is implemented at the facility. Residents are supported to remain safe and stay independently mobile as possible with oversight and assistance. There are systems and processes for the use of restraints and enablers should these be needed. Alternatives to restraint use are investigated to maintain the dignity and safety of each resident with their and their family member's involvement.

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 registered nurse responsible for infection prevention and control has a defined role to manage the environment and minimise the risk of infection to residents, staff and visitors. The service has a clearly defined and documented infection control programme that is reviewed at least annually.

Staff files, observation and interviews verify initial and ongoing infection control education occurs.

Surveillance for infection is conducted monthly and annually and transferred to an annual electronic data sheet. There is evidence of a continued reduction in urinary tract infections and a proactive approach to continue this trend.

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	44	0	0	0	0	0
Criteria	2	91	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 Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was displayed throughout the facility. Residents and family reported that they were provided with copies of the Code as part of the admission process.</p> <p>Staff demonstrated knowledge of the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights.</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>Files reviewed included appropriate written consents by the resident. Staff during interview demonstrated good knowledge of consent processes. Families and residents interviewed verified appropriate consents occur as part of everyday practice.</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 and families interviewed reported that they were provided with information regarding access to advocacy services. Contact details for the Nationwide Health and Disability Advocacy Service was included in the admission package, with the brochure available at the entrance to the service. Education was conducted as part of the in-service education programme for staff.</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>Family reported that they are encouraged to visit at any time, and are always welcomed. Residents are supported and encouraged to access community services with visitors, or as part of the planned activities programme. There is evidence in residents' files that this occurs regularly. Staff were observed welcoming visitors and encouraging outings.</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 organisation's complaints policy and procedure is implemented at Bishop Selwyn. It meets the requirements of the Code and complaint forms are easily accessible to residents and families.</p> <p>The facility manager responds to all complaints and enters the details in the electronic event reporting system. (See also standards 1.2.3 and 1.2.4) The electronic reporting system and complaints received during 2016 were reviewed with the manager. She demonstrated her understanding of both the requirements of the Code and Ultimate Care's process for responding and managing complaints. Responses are sent within the timeframes of the Code and are respectful, acknowledging issues and take an open approach to addressing the issues raised.</p> <p>Staff members interviewed also described their responsibilities for responding to complaints. In the 2016 resident and family/whānau satisfaction survey 25 residents and 11 family members took part in the survey. All respondents were either satisfied or very satisfied with their ability to raise concerns without it affecting the care they receive. Similar feedback was received from residents and family members interviewed during this audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Family and residents interviewed reported that the Code was explained to them on admission, was included as part of the admission pack, and time was allowed for them to understand the information. Nationwide Health and Disability Advocacy service information is also included in the admission pack with brochures available at the entrance and hallways of the facility. Residents and family interviewed reported that they were aware of their right to access advocacy services but they had not needed to do so.</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>Residents and family interviewed reported that the residents are treated in a manner that shows regard for the resident's dignity, privacy and independence. Files reviewed indicate that residents received services that are responsive to their needs, values and beliefs.</p> <p>Residents, family, and one general practitioner (GP) interviewed did not express any concerns regarding abuse or neglect.</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>	FA	<p>There was no residents who identified as Māori at the time of audit. The clinical services manager (CSM) reported that there are no barriers to Māori accessing the service. Staff interviewed demonstrated a good understanding of services that are commensurate with the needs of Māori.</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>Residents' files reviewed demonstrated consultation with the resident and family on the resident's individual values and beliefs. Families reported they were consulted with the assessment and care plan development. Staff interviewed demonstrated good knowledge on respecting each resident's culture, values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff employment documents had clear guidelines regarding professional boundaries. Families and residents interviewed reported they were very happy with the care provided. Families and residents expressed no concerns regarding breaches in professional boundaries and all reported a very high satisfaction with the caring, calming and professional manner of the staff.</p>
<p>Standard 1.1.8: Good Practice</p>	FA	<p>There are several examples of good practice implemented at Ultimate Care Bishop Selwyn. Evidence-</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>based practice was observed, promoting and encouraging good practice, including consultation with the wound nurse specialist for a pressure injury.</p> <p>Registered nurses (RNs) are supported in ongoing professional development. All but one registered nurse (RN) are trained in interRAI assessments, and all residents have the interRAI fully implemented.</p> <p>RN's are also supported to be clinical champions and implement projects in line with clinical practice to improve outcomes for residents.</p> <p>There is regular in-service education and staff access external education that is focused on aged care and best practice and fully supported by the organisation.</p> <p>An electronic risk management system including in depth analyses and benchmarking is implemented. Engagement of external health professionals to support staff contributes to evidence based outcomes for 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>	<p>FA</p>	<p>Staff demonstrated that they understand the principles of open disclosure. Residents, family and the GP confirmed they are kept informed of the resident's status, including details of events which may have affected the resident. Evidence of open disclosure is documented within each resident's file. All interviewees reported that communication is excellent.</p> <p>At the time of this audit there were no residents who required interpreter services to ensure effective communication. Both the CSM and staff during interview demonstrated their understanding of the organisation's processes for obtaining these services should they 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 Group is a private organisation managed by a chief executive officer. There is a senior management team at the Group's National Support Office (NSO) made up of general managers supporting the main functions of the Group including a clinical and operations team. There is also a regional manager who provides additional oversight to the facility. The facility manager provides weekly reports to the regional manager and NSO on key indicators from their combined business and quality plan which links to the organisation-wide goals.</p> <p>The facility manager has been in her role at Bishop Selwyn since November 2011. She has extensive clinical and management nursing experience. During interview, and from reviewing documents relating to business planning process, the Bishop Selwyn team reviews their goals annually and develops new goals for the next year ahead.</p> <p>Staff members reported their satisfaction with the facility manager in her role.</p>

		<p>On the days of the audit 69 of the 78 beds were occupied by residents receiving subsidised care. Twenty eight (28) residents are receiving hospital level care and 41 rest home level care. There is a mix of studio rooms which people purchase an occupational right agreement (ORA) to live in. These residents may or may require subsidised care. Of the 69 residents five were in studio rooms and five were respite residents.</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>There are appropriate arrangements for senior staff members to cover a temporary absence of the facility manager. This has been put into practice over the past 12 months with facility manager providing assistance at two other Ultimate Care facilities. At interview with a range of staff there is confirmation of the arrangements to 'replace' the facility manager. She was available by telephone if needed, however the Bishop Selwyn team, with assistance from their regional manager and the NSO team are available when required.</p> <p>Review of all records from during the time of the facility manager's absence demonstrated that all organisational systems continued to be implemented during her absence.</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>	FA	<p>There is an effective quality and risk management system operating at Bishop Selwyn. This incorporates the requirements of this standard. Using the template for all Ultimate Care Group quality and risk management plans the facility manager and quality committee develop an annual quality plan with objectives for each calendar year. The 2016 plan was reviewed during the onsite audit along with the ongoing quality committee minutes and documents relating to the review of the 2015 plan and objectives.</p> <p>All policies and procedures are maintained from NSO from the clinical and operations team. Evidence was seen during the audit of updated policies being sent through to the facility for staff members with changes and updates identified. All documents are controlled and those seen prior to and during the audit are current. The document management system ensures that obsolete documents are removed from circulation. Appropriate references to the interRAI assessment tool are included in the organisation's policies and procedures.</p> <p>The quality committee meets monthly and, like all the regular meetings held at the facility, has a standard meeting agenda. The committee reviews and has oversight of collated adverse event data. There is a quality assurance contractor who works one day a week. Each meeting includes discussion of all types of adverse events required by this standard. The adverse event electronic system provides summary graphs and reports at three monthly intervals during the year. To date Bishop Selwyn has received two of these reports and there is evidence of the committee reviewing the summary data and using it to inform the review of their quality goals as well as the analysis of their collated incident data. Since May 2016 Ultimate Care has been benchmarking their data with another large group of aged care facilities in New</p>

		<p>Zealand. At interview with the facility and clinical services managers they reported that this has provided the committee with a useful perspective on their own performance.</p> <p>There is a culture of continuous improvement at Bishop Selwyn. All staff members interviewed described their responsibilities for quality, adverse event reporting, hazard identification and risk management. The hazard and risk registers are reviewed regularly in line with policy and there is regular monitoring by the health and safety committee. Since the last onsite audit the facility was the site of Ultimate Care Group's Accident Compensation Corporation Workplace Safety Management Programme audit and achieved tertiary status accreditation in September 2014. Corrective action plans are developed in response to internal audits and these are monitored through the quality and health and safety committees, and in response to individual adverse events and complaints. (See also standards 1.1.13 and 1.2.4). The risk register has risks appropriate to the size and scope of the facility and there is notification to the NSO and the regional manager when required in relation to risks.</p> <p>Staff members interviewed from across the facility were consistent in their reporting of the systems and processes in place relating to quality and risk management. Documents reviewed confirmed that the systems for managing quality are occurring as described in policy and as reported by staff and managers. Meetings occur consistently. Overall the feedback from residents and family members interviewed during the audit was positive. This confirms the results from the 2016 satisfaction survey.</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>The organisation has guidelines for reporting of all types of statutory and essential notifications. These are made appropriately when required. As of January 2016, all pressure injuries are reported on incident forms (and recorded on the wound assessment and management care chart). All Stage 3 and above pressure injuries are reported to HealthCERT and an ACC Claim is made. All pressure injuries are included in the monthly clinical indicator reports. During interviews the facility manager understood her responsibilities for essential notifications.</p> <p>All adverse events are documented on the organisation's incident/accident form. The process for reporting and recording adverse events is known and understood by all staff members. They are trained in this at orientation and annually thereafter. During interviews they described their responsibilities and files reviews confirmed that practice is consistent with the documented procedure.</p> <p>The electronic recording system provides a link to NSO and a system for the recording and monitoring of corrective action plans and escalation of risk when needed. Each resident has a running log of any adverse events on their file, along with the communication with their family/whānau. (Refer also standard 1.1.9).</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>The human resources system utilises the suite of policies and procedures of Ultimate Care Group. The facility manager has overall responsibility for the recruitment and selection of all staff. A sample of personnel files was reviewed during the audit and this confirmed that procedures are implemented. Nursing staff have their practising certificates validated during the recruitment process. Monitoring of the practising certificates or professional registration of all health or allied health staff employed by, or contracted to work at, Bishop Selwyn occurs. This was reviewed with the facility manager and all were current.</p> <p>A comprehensive education plan is in place which includes regular in service sessions each month, 'spot topics' at staff meetings, external training and targeted development for individuals. There are three registered nurses who are preceptors for the Nurse Entry to Practice (NetP) programme for graduate nurses through Canterbury District Health Board (CDHB). The facility manager has obtained funding for one of the kitchen team to gain their New Zealand certificate in Cookery, level four. The seven health and safety team members have attended training to level three. The routine training programme incorporates all the requirements of these standards as well as role specific induction and orientation for each new staff member. A number of staff members stated that education is a particular focus at the facility. This was evident through interviews with staff from across the facility who spoke positively of the opportunities and access to education. They value the encouragement they receive to develop and learn, whatever their role. Ongoing training and development of staff members is beyond the expected full attainment.</p> <p>All of the registered nurses employed by Bishop Selwyn, except for the facility manager, have completed interRAI training and maintain their competency to complete interRAI assessments. When they are due to renew their annual competency assessment the nursing staff provide the notification of the completed assessment to the clinical services manager who maintains a record of this. The clinical services manager has completed the interRAI manager's training.</p> <p>Staff members who support residents in the studio units which are occupied under ORA's, receive the same training as those in rest of the facility. In addition staff are trained in the Retirement Villages Code of Residents Rights and aspects of the Code of Practice to meet the requirements of the organisation's certification to the Code of Practice. There are residents in the studio units who do not require subsidised care and who are independent. These residents may transition to requiring care over time.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	<p>FA</p>	<p>The organisation has a documented process for safe staffing at each facility. A rostering tool is used which includes the Ministry of Health's Safe Staffing levels as a guideline within the tool. The rosters were sampled with the facility manager during the audit. She prepares a weekly roster each Friday for the coming week. The rostering tool reflects the care needs of the residents in the facility at the time so changes can be made to reflect changes in need.</p>

<p>and/or experienced service providers.</p>		<p>The roster demonstrated that staffing levels are safe for the acuity levels of the residents at Bishop Selwyn at the time of the audit. Staff members interviewed reported that they work effectively as a team and there are sufficient staff to meet people's needs. Residents and family interviewed similarly confirmed that they are satisfied with the standard of care provided and the level of staffing.</p> <p>There are sufficient nursing and care giving staff to meet the needs of additional residents in the studio units should they change from being independent to requiring subsidised care. The nursing team structure has an additional staff member in the team leader role and there are sufficient numbers of RNs, ENs and care givers employed to increase staffing levels if resident numbers rise.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>A review of clinical records and interview with the manager confirmed that information is entered into each resident's integrated file in a timely manner. Records reviewed were integrated, dated signed and legible and include the designation of the staff member.</p> <p>Current resident records are not publicly visible. InterRAI assessment information is accurately entered into resident records.</p> <p>Current residents' old notes and archived records are stored in a secure room. These were observed to be well organised and dated.</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 facility manager (FM) or clinical services manager (CSM) logs enquiries and documents interview responses to gauge if the prospective resident is suitable for their home. The residents are required to have an assessment for either hospital or rest home level of care. The FM and CSM reported that they communicate regularly with referring agencies to ensure admissions are appropriate for the facility.</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 admission is required to the acute care hospital, the service completes a transfer form. The referral process documents any risks associated with each resident's transition, exit, discharge, or transfer. With the transfer form, the RN also provides a copy of any other relevant information, such as the medication chart. A file of the one resident reviewed with a recent admission to the acute care hospital evidenced that the transfer from the hospital was effectively managed.</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>Most medicines are supplied by the pharmacy in a blister pack administration system. The medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered. The pre-packed medicines and the signing sheets are compared against the electronic medicine prescription. The GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists. An electronic medicine prescription system is implemented.</p> <p>Safe medicine administration was observed at the time of audit. All records were accurately completed.</p> <p>The medicines and medicine trolley are securely stored. The medicine fridge is monitored for temperature, with the sighted temperatures within medicine storage guidelines. The controlled drugs are stored in a locked safe in a secure room.</p> <p>All the electronic medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. The medicine charts recorded the regular, short course and pro re nata (PRN – as required) medicines for each resident. When medicines were discontinued, these were removed by the GP. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification was recorded for all staff who administer medicines. All of the medicine charts were reviewed by the GP in the past three months.</p> <p>Medication competencies were sighted for all staff that assist with the medicine management; this included the RN.</p> <p>The RN reported that there was one rest home resident who self-administers inhalers, and this was sighted to be in accordance with the facility's policy and procedures.</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 current menu was reviewed by a dietitian as suitable for the older person living in long term care. If there are changes to the menu these are recorded and referred to the dietitian at the next review. A diary records any changes. All residents interviewed reported great satisfaction with the food and food services.</p> <p>Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets had these needs met.</p> <p>There is food available 24 hours for those who wish to snack at night.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. Evidence was seen of all kitchen staff having completed safe food handling</p>

		certificates.
<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 FM and CSM report that they have not declined entry to any potential residents who have an appropriate needs assessment. Both confirmed that if entry to the service was to be declined the referrer, potential resident and where appropriate their family, would be informed of the reason for this and of other options or alternative services.</p> <p>The facility's admission agreement contained information on the termination of the agreement. This documents that if a resident's needs changed and if the service can no longer provide a safe level of care to meet the needs of the resident, they would be reassessed for the appropriate level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The service has implemented the interRAI assessment tool for all residents, and these are completed by the RNs. The interRAI is used to inform and develop and review the care plan. Care plans sighted reflected the needs of the residents as identified in the interRAI and other assessments. All residents' physical, psycho-social, cultural and spiritual needs are fully documented as part of the assessment process. Goals are individual and consistent with meeting the outcome needs of the residents.</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>Care plans reviewed were individualised and developed from interRAI and other assessment tools, reflecting the resident's individual needs. The file of the residents reviewed using tracer methodology had care plans that identified the residents' needs and care requirements specific for a pressure injury (PI) and falls risk. The residents' files and care plans demonstrated service integration. The files had one main folder that contained the medical information, nursing assessment, care plan, routine observations, activities, therapies, family correspondence and specialist consultations.</p> <p>Residents and family interviewed reported that they are consulted at the time of care plan reviews and staff delivered services in line with their wishes. The GP interviewed expressed a high level of satisfaction with the care provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed</p>	CI	<p>Services are being delivered according to information in resident's individualised care plans.</p> <p>Short term care plans are being developed for short term problems, such as skin tears, wounds, decreased mobility and infections. Progress notes reviewed demonstrated that care and support was consistent with the identified problems, personal goals and interventions, as described in the care plans.</p>

needs and desired outcomes.		<p>Staff informed that they report any concerns about a resident, such as a change in their condition, both in the progress records and to the RN, and this was confirmed in documentation reviewed and interview with the RN.</p> <p>Residents spoke very well of the level of care and support provided and consistently stated that all of their needs are being met. The GP during interview confirmed that his interventions ordered are always implemented and the facility goes above and beyond to improve outcomes.</p> <p>Improving resident outcomes through interventions is strength of the facility demonstrating continuous improvement.</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>On admission a personal profile is completed for each resident. A detailed and individualised activity plan is developed and updated during review. The activity plan for individual residents is included in the interRAI care plan. A range of activities are planned for each month and copies of the monthly activity schedules show that options are varied. One diversional therapist (DT) and two activities persons implement the activities programme. During interview the activities person reported that options for group activities are discussed regularly with residents.</p> <p>Residents interviewed are happy with the activities available. They confirmed there is no compulsion to attend, or participate if they are in the lounge during activity time. Residents who wish are assisted to undertake activities on a one to one basis and a record of this is retained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluation of both short and long term care plans is occurring within recommended timeframes with detailed outcomes/goals included. Six monthly reviews of care plans are occurring. Both residents and family are consulted and are informed when changes are identified. This was confirmed during interviews and via the multidisciplinary review form.</p> <p>Information is being included in progress notes and changes are being made to interventions on care plans when indicated. Staff interviewed stated they are consulted prior to evaluations.</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</p>	FA	<p>One GP visits about 80% of the residents, other residents maintain their own GP. The GP arranges for any referral to specialist medical services when it is necessary. The residents' files reviewed had appropriate referrals to other health and diagnostic services. The CSM and RN confirmed that they utilise external services as much as possible. Referrals were sighted for consultations with general medicine, surgery, mental health, pathology, dietitian, radiology, WNS and cardiology services. The GP interviewed reported that appropriate referrals to other health and disability services were well managed at the</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>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>	<p>FA</p>	<p>There are documented processes for staff members to follow when handling waste, hazardous substances and these are available to staff. They are on display in the laundry, cleaner's storage room in the sluice rooms and in the policy and procedure manuals in each of the nurses' stations. During interviews with staff members all hazardous substances and chemicals were stored securely, when in use, when stored and when in transit for disposal. Material safety data sheets are available to housekeeping and laundry staff for the products in use.</p> <p>Staff members from the housekeeping and laundry team were interviewed and stated that they had received training both which products to use and how to use them. They have adequate supplies of personal protective equipment (PPE) to use. This includes routine use and for specialist cleaning and during outbreaks. During the audit visit staff members were observed wearing and using PPE.</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 facility has a current building warrant of fitness which expires on 30 June 2017. All associated checks and monitoring are occurring in relation to the warrant of fitness.</p> <p>Bishop Selwyn is a purpose built aged care facility. It is on one level with handrails in all of the wide corridors and low rolling resistance flooring both of which promote independence and mobility for residents.</p> <p>The facility has three courtyard gardens within and around the buildings and the configuration means that many of the residents rooms look onto the gardens and residents can access them directly. Gardens have safe access and seating.</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</p>	<p>FA</p>	<p>There are adequate toilet, showers and bathing facilities to meet residents' needs. There are additional toilets available for residents throughout the facility.</p> <p>All studios have their own ensuite bathroom containing a toilet, shower and hand basin. There are 27 larger sized rooms also with full ensuite bathrooms, and two of these rooms which share and ensuite bathroom. The remaining rooms are variable in size but overall smaller. Each room has an ensuite toilet and hand basin, while some rooms have a shared full ensuite. Those residents who do not have a shared ensuite use one of the three additional showers available.</p>

<p>assistance with personal hygiene requirements.</p>		<p>Toilets identified for staff and visits are also available.</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>As noted in standard 1.4.3 there is some variation in the size of rooms throughout the facility with all rooms meeting the needs of the residents who use them, depending on need level.</p> <p>Hospital level care residents occupy rooms which can accommodate the equipment they require. Doorways and corridors are sufficiently wide to accommodate the resident being moved if this is necessary.</p> <p>Observed during the audit was residents having personal items and furniture of their choice in their bedrooms. Residents' personal preferences were respected by staff members in where and how they wanted items placed in their rooms.</p> <p>The facility is seeking approval to have the studio apartments to be used by couples requiring subsidised care. Residents purchase an occupational right agreement (ORA) for studios. The rooms are the largest of those available at Bishop Selwyn and can accommodate twin beds. This still allows for equipment to be used in the room and / or mobility equipment for the resident(s) and for them to move about their unit.</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>Bishop Selwyn has three dining room / lounge areas within the facility. One is for residents who require hospital level care. This large room can accommodate all the residents who use it all of whom use mobility equipment either independently or which assistance. There is another dining room and lounge area for residents at rest home level which has room for seating for these residents most of whom are independently mobile. A third dining room is for studio residents who are not receiving subsidised care.</p> <p>In addition to these three areas there is an additional large room for activities which includes inside bowls with an adjacent small kitchen to cater for functions. There is a small 'conservatory' area between two of the courtyard gardens. This was observed being used during the audit visit.</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>The laundry staff member and one of the housekeeping team were interviewed. Both reported that they check the effectiveness of their cleaning as they complete tasks during their shifts. Both staff members have a checklist of the tasks they complete on a daily basis so that if there are concerns this can be monitored. They know that the quality assurance person also completes regular internal audits and that they receive feedback from these if any issues are identified. Copies of the internal audits of cleaning and laundry services for 2016 have been reported to the quality and health and safety committee and the audits noted compliance with the audit requirements when completed.</p>

		Results of the 2016 resident and family satisfaction survey are that respondents are satisfied that their room / studio is kept clean and hygienic, that clothes are returned from the laundry in a satisfactory condition and that the cleaning and laundry staff are friendly, polite and helpful. During the days of the audit the facility was in a tidy, clean and well-presented state.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Staff members receive training in fire safety, evacuation of the facility and preparation for emergencies and security arrangements at orientation. There are fire evacuation practices every six months and the annual mandatory training day includes a refresher on the other aspects of this training. Review of personnel files confirms that staff members attend the scheduled training. A range of staff members from different parts of the facility were able to describe these procedures.</p> <p>There is an approved evacuation scheme for the facility and changes to the plan have been approved in the past. Copies of the evacuation plan are on display throughout the facility and fire suppression equipment is available throughout. There is a sprinkler system in the building.</p> <p>Bishop Selwyn has alternative energy and utility supplies available on site. Emergency response kits are maintained around the facility. These are monitored monthly by members of the health and safety committee. Recent meeting minutes have described the process of committee members completely the scheduled internal audit of the kits and the equipment and other supplies. All aspects of emergency preparedness were compliant with Ultimate Care's systems. This includes reviewing the civil defence plan for the facility (sighted) which is also up to date.</p> <p>The call bell system operates through the use of pagers worn by staff members and a visual display of the room number visible from each of the nurses' stations and in all the corridors. Staff members were observed responding promptly to activated call bells during the audit. Family member respondents in the 2016 satisfaction were very satisfied with the availability of staff members within a reasonable time frame. In studios a second call bell is installed by the second bed when a couple moves into a studio. Additional call bells are added in the unit if required or at the request of residents. This was observed in one studio next to a 'favourite chair'. There are two call bells installed in studio bathrooms.</p> <p>The registered nurse team leader described the security arrangements. All external doors are locked each evening at 4.45pm. There is a doorbell at the front door for family members to gain access. There is appropriate monitoring of the facility during the evenings and overnight.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	FA	All bedrooms, lounge/ dining and other rooms used by residents have opening windows with safety latches. This allows for windows to be opened and allow fresh air to circulate. Bedrooms have large external windows which allow natural light and have curtains or other window coverings.

<p>adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>The facility has electric heating, either wall mounted heaters or ceiling heaters. The large rest home lounge has a gas operated fire. All heaters have safety guards. During the days of the audit the facility was a comfortable temperature.</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>The infection control (IC) RN was interviewed. The job description for the infection control coordinator role is clearly defined. There are clear lines of accountability for infection control matters at the service through the staff meetings. The FM and CSM attends these meetings. The IC RN provides a report to the staff meeting on IC matters.</p> <p>The annual review of the infection control programme has been conducted within the past 12 months.</p> <p>The service has clear policies about staff, residents and visitors suffering from, or exposed to and susceptible to, infectious diseases. Staff reported that they do not come to work if they are unwell. Notices are placed at entrances to ask visitors not to visit if they are unwell, or have been exposed to others who are unwell. There was sanitising hand gel throughout the service for residents, visitors and staff.</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 IC RN attends ongoing education. The RN reported that the facility can access external advice from the hospital IC consultant, the GP, DHB and Ministry of Health services as required. Infection control is discussed at the staff and ward meetings and staff education occurs randomly as part of the on-site audit process.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented</p>	<p>FA</p>	<p>Ultimate Care Bishop Selwyn uses the organisation's detailed policies and procedures. Staff demonstrated good infection prevention and control practices reflective of policy. These have been designed to be fit for purpose for the Ultimate Care Group residential care environment.</p>

<p>in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control education is provided by the IC RN who has maintained her knowledge of current practice. The in-service education programme contained education and attendance sheets for IC education sessions. These sessions were referenced to current accepted good practice. Infection control practices are included in induction and orientation for all new staff.</p> <p>Informal education is provided as required to residents and their family. The RN gave examples of encouraging residents with fluids and personal hygiene for a resident with recurring urine infections.</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 programme.</p>	FA	<p>The CSM and IC RN were interviewed. Monthly and annual analysis of infections are occurring and reported at monthly staff and quality meetings and reported to the Ultimate Care support office. Infection surveillance records show a decrease in the incidence of urinary tract infections, over the past three years. The facility is proactively implementing increased hygiene measures and fluid rounds to continue to maintain this trend. An electronic risk assessment tool has been implemented to assist with the analysis of infections.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Ultimate Care Group has appropriate policies and procedures to meet the requirements of the restraint minimisation and safe practice standard. The clinical services manager is the restraint coordinator at the facility and was interviewed during the audit. A restraint free environment is in place and similarly no enablers are used. Residents are assessed for their needs in relation to mobility equipment, any falls risk and any other support needs which may be relevant.</p> <p>The RN meeting minutes reflect the discussion of alternative strategies to restraint use when these have been requested by families (ie, bed rails for safety whether this would be an enabler or a restraint), ongoing monitoring of residents wellbeing and staff practice to ensure that this does not impinge residents normal freedom of movement.</p> <p>At interview with staff members they described how residents are monitored for safety and their mobility and wellbeing is supported. Training in restraint policies and procedures, de-escalation techniques, the restraint free philosophy, and how to practice this occurs is provided for all staff at the facility. Review of personnel files and training confirms that this training occurs as scheduled.</p>

		No residents were observed with restraints in use and all residents using mobility equipment were doing so independently and safely.
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>The facility manager is responsible for planning and implementing the ongoing training and development programme. In 2015 a quality objective was planned to improve resident outcomes through staff education. Additions to the routine annual training programme included the allocation of clinical champion areas to registered nurses, nursing staff enrolling in post-graduate study or other external training, the addition of specific clinical learning available through CDHB, and provision of additional in-service training for caregiving staff members on specific areas of residents needs to improve their knowledge and skills.</p> <p>This objective was documented in project form and reported against through the monthly quality committee meetings. At the end of 2015 this was reviewed by the quality committee and continued as an objective for the 2016 year.</p> <p>Staff interviewed during the on-site audit reported that they value</p>	<p>There is a detailed training and development programme for all staff which focused on providing a high quality service delivery. The programme has been developed with consideration to different learning styles and incorporates on line learning as well as ‘classroom based’ learning. There is evidence of increased attendance at training from 2014 to 2016. Five registered nurses have had their professional development and recognition programme (PDRP) portfolios assessed in this time and two more are awaiting assessment.</p> <p>The 2016 resident and family satisfaction survey results demonstrates that, overall, Bishop Selwyn’s results exceed those of the Ultimate Care Group average for all questions asked. All questions are rated as ‘satisfied’ to ‘very satisfied’ across a range of</p>

		<p>the access to education and the opportunity to develop their skills and knowledge. They discussed the importance of providing the best level of care and support possible to the residents at Bishop Selwyn. This has resulted in a high level of resident satisfaction.</p>	<p>indicators relating to competence of staff and service delivery.</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>CI</p>	<p>Two quality improvement projects have been implemented by RN clinical champions regarding resident interventions at the facility. The projects commenced in 2015: a) to reduce acute hospital admissions; and b) to implement the use of safe mobility aids and strategies to reduce the number of resident falls.</p> <p>a) The RN champion discussed with residents / family and care team (GP, RN's) on future decisions of treatment options and priorities as well as the place of treatment (acute hospital or remain at Bishop Selwyn). Meeting minutes, GP notes and interview, progress notes, multidisciplinary team (MDT) and family communication forms of five residents were reviewed.</p> <p>The outcome and analyses of the information and feedback from residents and family on the care and treatment provided at Bishop Selwyn showed a reduction in the number of acute hospital admissions. The collective inputs from resident-family and care team, including GP with the decision to not hospitalise and the provision of often end of life care at Bishop Selwyn emphasised the resident's preferred outcome.</p> <p>This prioritises the resident's comfort and choice of place to be cared for and the treatment modalities provided. RN's on-going professional development enhances these choices to be available for residents.</p> <p>b) Implementing a Traffic Light Strategy and the use of wheelchairs as mobility aids. The review and outcome analyses showed an overall reduction of falls in the hospital wing. Documentation reviewed shows in both the rest home and hospital wings overall falls rates in 2015 and 2016 are below the 6.38% benchmark rate.</p>	<p>Two quality improvement initiatives have been implemented, reviewed and changes implemented to improve the outcomes of residents. The outcome and analyses of the interventions showed the residents quality of life has improved markedly.</p> <p>Residents are more mobile and independent and equally staff are more confident in allowing residents to mobilise independently.</p> <p>Two residents and one family member were interviewed, and verify the residents' quality of life and outcomes have improved since the implementation of the strategy. This positive outcome for the residents exemplifies continuous improvement principles.</p>

		<p>Two resident files were reviewed. Staff during the initial evaluation identified residents who were chair bound. Both residents have Traffic Light and wheelchair mobility implemented.</p> <p>The positive and improved outcome continues to be evaluated on a regular basis to ensure the effectiveness of the interventions remain effective. Residents are more mobile and aware of their capabilities / limitations (through visual prompts of the traffic lights). Staff are more confident in allowing residents to mobilise independently. Residents are now able to mobilise freely and independently using wheelchairs. Family/resident feedback, progress notes and review notes confirmed the improved outcome for the residents.</p>	
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End of the report.