

The Ultimate Care Group Limited - Ultimate Care Churtonleigh

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 Churtonleigh	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 21 February 2018	End date: 22 February 2018
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:	27	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ultimate Care Churtonleigh provides rest home and hospital level care for up to 42 residents. The service is operated by the Ultimate Care Group and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

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

This audit has resulted in a continuous improvement rating relating to the increase in attendance at training. There were no areas requiring improvement identified.

Consumer rights

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

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to formal interpreting services if required. The service has linkages with a range of specialist health care providers which contributes to ensuring services provided to residents are of an appropriate standard. A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with

corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using integrated hard copy files.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses all of whom have been assessed as competent to do so.

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and is evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. At the time of audit, one resident was using an enabler and eight were using restraints. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.
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The infection prevention and control programme, led by an appropriately trained infection control co-ordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board and the organisation's clinical advisory panel. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	1	100	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>Ultimate Care Churtonleigh has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in internal audit results and training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to</p>

		<p>consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were also displayed throughout the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service.</p> <p>The facility also has their own residents' advocate, who has only recently taken on the role after the previous advocate's retirement. Interview with the advocate verifies understanding of the role and willingness to act on the resident's behalf if required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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 Ultimate Care complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaints and compliments forms are available in the facility where residents and family members can freely access them.</p> <p>The complaints register reviewed showed that six complaints were received in 2017 and that there were no complaints so far in 2018. All complaints received in 2017 had appropriate actions taken, had been</p>

		<p>managed through to an agreed resolution, and were documented and completed within required timeframes. When needed action plans showed any follow up and improvements have been made.</p> <p>The facility manager is responsible for complaints management and follow up, with assistance from the Audit and Compliance Manager from Ultimate Care's national support office. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required of them in their roles.</p> <p>There have been no complaints received from external sources since the previous audit.</p> <p>Residents and family members interviewed during the audit stated they are comfortable raising any concerns at any time and the facility manager has an 'open door' policy.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents (seven) and family members (five) interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</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 families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and in discussions with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural,</p>

		<p>religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training records.</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 were no residents in Ultimate Care Churtonleigh at the time of audit who identified as Māori, however interviews verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed. A cultural advisor from the region's hospice service is available to the service for guidance if required.</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 verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met. Training on cultural awareness was provided to staff in June 2017.</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>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when</p>

		interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies overseen by the group’s clinical advisory panel, input from external specialist services and allied health professionals, and staff ongoing education opportunities. RNs have access to the Capital & Coast District Health Boards (CCDHB) professional development programme. The completion of the orientation package, a requirement for all new staff employed at Ultimate Care Churtonleigh, ensures all new employees have attained the Level Two Certificate in Health and Wellbeing. Eleven of seventeen caregivers employed at Ultimate Care Churtonleigh have achieved the level three or level four certificates. Staff reported they receive management support for external education to support contemporary good practice.</p> <p>The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Other examples of good practice observed during the audit included all staffs’ commitment to ensuring residents individualised needs are addressed, all members of the team are valued and respected, and an environment that fosters a relaxed homely feel where residents and family members feel staff go “above and beyond” in providing the care they need.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their own or their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via Interpreting New Zealand or the CCDHB when required. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services</p>

		were rarely required and all present residents speak English.
<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>The Ultimate Care Group (Ultimate Care) has a company-wide annual strategic business plan. This is reviewed annually and outlines the purpose, values, scope, direction and goals of the organisation. The document describes annual objectives and the associated operational plans. A sample of monthly reports to the national support office from the facility manager showed adequate information to monitor performance is reported. This includes occupancy data, adverse event information, emerging risks and issues, enquiries for potential residents, staff training, and completion against the quality and risk management plan (see also Standard 1.2.3).</p> <p>Ultimate Care Churtonleigh is managed by a facility manager who has a range of relevant experience. The current manager was appointed in March 2017. She is a registered nurse who no longer maintains her practising certificate. She has worked in catering, hospitality, health recruitment and childcare and held management positions in these fields. Her experience in this range of sectors is evident in her understanding of the facility management position and demonstrated during the audit and in review of documents and other evidence. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager has attended Ultimate Care Group's leaders' annual forum and attends other relevant training. She is supported in managing the facility by a clinical services manager (CSM) who has been at Ultimate Care Churtonleigh for 12 months and is an experienced registered nurse. Although the CSM is currently appointed in an acting capacity and has held the role for two months prior to the audit, she demonstrated competency and understanding of the role.</p> <p>The service holds contracts with CCDHB for Age Related Residential Care (rest home level care, hospital care – geriatric and non-acute medical), Short term (respite) care and Day Stay services.</p> <p>Ultimate Care Churtonleigh has 42 certified beds with nine double rooms. Thirty-two rooms are dual use and two rooms are rest home only. These are two apartment style bedrooms which are upstairs. All rooms are currently occupied by individual residents. On the first day of the audit there were 27 residents; nine rest home level, 17 hospital</p>

		level and one respite resident.
<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>When the facility manager is absent, the acting clinical services manager is designated to carry out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the experienced registered nursing team at Ultimate Care Churtonleigh with support from the Ultimate Care Group (UCG) national clinical coach and clinical operations team at the national support office.</p> <p>Staff reported the current management team work well together.</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>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of adverse events, complaints and compliments, internal audit activities, a regular resident and family satisfaction survey, monitoring of clinical outcomes, infections, wounds and pressure injuries.</p> <p>A range of meetings are regularly held at Ultimate Care Churtonleigh. These include staff meetings, quality, registered nurse, and restraint and infection control. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the meetings. Staff reported their involvement in quality and risk management activities through these meetings, and occasionally, internal audit activities.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. These are recorded with the internal audit, specific adverse event or other source document. Management reports include notifications and updates being given to national support office of progress.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey (conducted in mid-2017) showed that Ultimate Care Churtonleigh rates well against all indicators of satisfaction and the UCG norms. Where there are some areas which are below the target threshold for satisfaction, the facility manager has created a corrective action plan in the 2018 quality plan. The one area of difference between family and resident feedback is in satisfaction with</p>

		<p>the environment. While the resident feedback is at approximately 1.6 on a 0 – 3 rating scale, family feedback is at 2.4 which are closer to the UCG average of 2.5. (See also Part 4 of this report.)</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. This is managed by Ultimate Care Group's national support office and has involvement from facility and clinical services managers in the Group.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register for Ultimate Care Churtonleigh was reviewed and is current. It demonstrated frequent monitoring and reviews through the calendar year. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. These are entered into an online system which links to UCG national support office. This enables Ultimate Care Churtonleigh to analyse and evaluate all the adverse events which occur and for the clinical support team and national office to have oversight and provide support when needed.</p> <p>A sample of adverse event forms reviewed showed that these were fully completed, events are fully investigated, action plans developed and actions followed-up in a timely manner. Event data is collated, analysed and graphs of this information is provided to the facility by national support office through the clinical services manager each month. Examples of the latest data for January and February 2018 was seen in the nurses' station and the staff room. Staff members interviewed reported that they receive this information, that it is discussed with them at meetings and they are involved in corrective action planning when this occurs.</p>

		<p>The facility manager described essential notification reporting requirements. They advised there has been no requirement to notify significant events to the Ministry of Health, or to other external organisations, since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes for the Group are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of personnel records (nine) reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff members interviewed who have completed UCG's orientation process reported that it has prepared them well for their role. Staff records reviewed showed evidence of completed orientation with a performance review after a three-month period. All staff have an annual performance appraisal, and this was confirmed through file review.</p> <p>Continuing education is planned on an annual basis and includes mandatory training requirements and competency assessments. Ten of seventeen care staff have either completed or commenced a New Zealand Qualification Authority qualification, with one other staff member about to complete their qualification. An experienced registered nurse (RN) is the workplace assessor for the programme. The remaining six staff are either casual or work part-time. Refer CI rating in relation to improvements to training.</p> <p>There are sufficient trained and competent RNs who are maintaining their annual competency requirements to undertake interRAI assessments. Training records reviewed demonstrated completion of the required professional development, and other position appropriate competency assessments for the RNs. This includes the acting clinical services manager who has completed all clinical training required of her as an RN and management training required of her in her clinical leadership position.</p> <p>Other staff members (kitchen, housekeeping, diversional therapy and</p>

		activities, administration and maintenance staff) also attend the required training and complete relevant competency assessments.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents, resident acuity and occupancy numbers at any time. There is a UCG rostering tool which is based on the Handbook Indicators for Safe Aged Care and Dementia Care for Consumers which is used to produce the roster weekly roster. This is produced for a month in advance.</p> <p>An afterhours on call roster is in place, which is shared by the facility manager and clinical services manager. Staff report that there is good access to advice when needed.</p> <p>Staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster confirmed adequate staff cover has been provided against the documented process, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) nursing care in the facility.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
Standard 1.3.1: Entry To Services	FA	Residents enter the service when their required level of care has been

<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>assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the acting clinical services manager (ACSM). They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the CCDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility following a fall, showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by</p>

		<p>dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit, however processes are in place to ensure this is managed in a safe manner, if a resident requests to self-administer medications.</p> <p>Medication errors are reported to the RN, ACSM and FM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are used for a minimal number of specified medications. Authorisation for these standing orders meet the guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a qualified chef and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>The kitchen has an up to date certificate of hygiene, issued by the local council. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have undertaken a safe food handling qualification, with</p>

		<p>kitchen assistants completing relevant food handling training. A food control plan has not been registered at the time of audit, however is in the process of being submitted for registration by the organisation.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. During interview, residents described how any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the ACSM and evidenced with a reassessment occurring for a rest home resident requiring hospital level care, and a review of a resident by the psycho-geriatric team to possibly place a resident in a secure unit. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission residents of Ultimate Care Churtonleigh are initially assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional</p>

		<p>assessment data, occurs every six months or more frequently as residents' changing conditions require.</p> <p>In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes.</p> <p>All residents have current interRAI assessments completed by one of six trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</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>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs,</p>	FA	<p>The activities programme is provided by a diversional therapist (18 hours/week) and a recreation officer (12 hours per week), over five days per week.</p> <p>A social assessment and history is undertaken on admission to</p>

<p>age, culture, and the setting of the service.</p>		<p>ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included twice weekly outings, monthly church services, visits by K9 pets, visits from the children from the local school, craft activities, bread making and monthly movie nights. Movie matinees are organised and run in the weekends.</p> <p>In addition to the monthly organised programme, additional arrangements accommodate individual residents or groups of resident's specific requests. These include enabling a gentleman to visit another facility to join in a 'men's group', enabling a small group of women's outings to a family members home for afternoon tea, a social meeting of a group of women to do crosswords and attention to ongoing requests as required. The activities programme is focussed on achieving the residents' and family members' goals. A resident, who once remained in their bedroom, now socialises while assisting others do a crossword. Another resident praised the facility for enabling residents' independence by providing access to a kitchenette where coffee can be accessed as desired. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs. Many family members commented on how happy their relative has been since admission to Ultimate Care Churtonleigh.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs</p>

		change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. This was seen in the files sampled.</p> <p>Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Appropriate personal protective equipment (PPE) is available throughout the facility and staff were observed to be using PPE during the audit.</p> <p>Two housekeeping staff members were interviewed during the audit. They confirmed that there are sufficient supplies of PPE available for use, that they receive training and have access to additional assistance if needed.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 26 October 2018) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the facility manager and observation of the environment. The environment is hazard free, residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</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>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a combination of shared ensuite bathrooms, as well as shared showers and toilets which are located throughout the facility. These have appropriate privacy locks and occupancy signage. There are secured and approved handrails in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>Staff and visitors have additional toilets with clear designation signage.</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>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>All bedrooms currently provide single accommodation. There are nine bedrooms which can accommodate two people, and are certified for this when shared approval has been sought from the residents. On the days of the audit no residents were sharing a room.</p> <p>There is room to store mobility aids, wheel chairs in rooms. There are also additional locations for storing some equipment. Residents and families reported the adequacy of bedrooms in the 2017 residents survey and this was confirmed during interviews at this audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	<p>FA</p>	<p>Communal areas are available for residents. The dining and lounge areas enable easy access for residents and staff. There are three</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>lounges and each has a different outlook. The large central lounge can accommodate residents during the daily activities programme in the facility. The two other lounge areas provide opportunities for smaller groups to be involved in other activities or individual pastimes. There is also a separate dining room.</p> <p>Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry by seven day a week laundry staff. The laundry staff member interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. The residents' satisfaction survey feedback from 2017 was positive about the laundry service confirming that it is managed well and clothes are returned in a timely manner.</p> <p>There is a designated cleaning team who have received appropriate training and a member of this team was interviewed. All chemicals were stored in a lockable cupboard and were in appropriately labelled containers. When dispensed into similarly labelled smaller containers for the cleaning trolley the bottles are kept in a lockable cupboard on the trolley.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and quarterly audits. These were reviewed for 2017. Both the housekeeping staff also talked about monitoring their own work and being able to make adjustments to the products used to improve the cleaning result when necessary.</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>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 21 March 2000. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 13 February 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures and personnel file review confirmed</p>

		<p>training.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the number of residents. The civil defence plan for emergency water is in place with water stored around the complex, and there are options for cooking on the facility's barbeque. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and staff were observed responding promptly during the audit. Residents and families reported staff respond promptly to call bells, and this was also confirmed in the 2017 resident and family satisfaction survey results.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the RN on duty checks these during the night shift.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows all curtains are in good condition. Some rooms have windows looking directly onto the street. These windows have a privacy film which does not restrict light coming into the room or the occupant's view out.</p> <p>Heating is provided by wall mounted (high up) electric heaters in residents' rooms and central heating in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at 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>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level. The infection control programme is reviewed annually and was reviewed in December 2017.</p> <p>The RN with input from the ACSM is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job</p>

		<p>description. Infection control matters, including surveillance results, are reported monthly to the ACSM and tabled at the quality/risk/staff meeting. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisation's national quality manager is informed of any IPC concern.</p> <p>Signage at the main entrance to the facility requests "Hugs not Bugs", if you are unwell please do not visit. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control co-ordinator (ICC) has appropriate skills, knowledge and qualifications for the role, however has been in this role for only a short time and is being assisted by the ACSM. The ICC has undertaken training in infection prevention and control, as verified in training records sighted. The Infection Control Committee includes the ICC, ACSM and a senior caregiver. The committee meets quarterly to discuss any IPC concerns and actions required. Well-established local networks with the infection control team at the DHB are available and expert advice from the organisation's clinical advisory group is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC and ACSM confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last three years and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and</p>

		practices. Audit results verified compliance with IPC policies.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in respiratory tract infections.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC and ACSM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers.</p>

<p>minimised.</p>		<p>There is a restraint coordinator who is relatively new in the position, and she is supported by the clinical services manager who provides support and oversight for enabler and restraint management in the facility. As the restraint coordinator was not on duty during the days of audit, the clinical services manager was interviewed. She demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities of the restraint coordinator.</p> <p>On the day of audit eight residents were using restraints and one resident was using an enabler. The equipment in use was the least restrictive option. The file for the resident using the enabler was reviewed and this confirmed that it is being used voluntarily at the resident's request. Similar processes are followed for the use of enablers as are used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with the clinical services manager.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, made up of the clinical services manager, restraint coordinator, the resident's representative, physiotherapist and doctor, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, a sample of three of the eight residents' files who are using restraints and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of enduring power of attorney (EPOA) involvement in the decision making was on file in each case. Use of a restraint, or an enabler, is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The restraint coordinator undertakes the initial assessment with the RN and care giving team involved in the resident's care, and input from the resident's EPOA. The clinical services manager described the documented process. Families</p>

		<p>involvement was evident on the files reviewed.</p> <p>The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised and the clinical services manager described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds and involvement in activities).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details and frequency. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated regularly and reviewed at each restraint approval group meeting which occurs three monthly. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families involvement in the evaluation process was confirmed in the evaluation documentation on files reviewed.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings.</p> <p>In January 2018, the clinical services manager completed the six monthly analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families.</p> <p>A six-monthly internal audit of files for residents with restraints is carried out and also informs this process. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the clinical services manager and caregiving staff confirmed that the use of restraint is actively minimised.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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>After commencing work at Ultimate Care Churtonleigh the facility manager noted the rate of attendance at in-service training sessions which was not sufficient to meet requirements. The in-service sessions were often scheduled weekly and the content was delivered in the same way as it had been over the past few years.</p> <p>The facility manager did an analysis of the in-service training, including completing the online training alternative herself. She interviewed staff members including those who were regular non-attenders and sought feedback from them about possible ways to improve the training.</p> <p>From July to September she changed the style of delivery of sessions and combined similar topics so that, wherever possible, one session was delivered each month. In September staff members were given</p>	<p>From October 2017 there has been a significant improvement in attendance at in-service training by staff in the facility. Attendance had been ranging from 25 or 30 % to 60% - 80% attendance at a small number of sessions. After analysing the existing training content and methods of delivering for in-service education, the facility manager overhauled the delivery of mandatory training. Sessions are more interactive, with similar topics combined together into one training per month if possible. Positive feedback was shared at staff meetings and is noted on training evaluations.</p> <p>These changes to delivering, clarity of expectations for attendance and combining sessions have led to an overall increase in staff attendance at training. Individual sessions have 85 to 95% attendance. The seven topics completed from October to December</p>

		<p>a clear message about required attendance at training.</p> <p>Since this initiative has been implemented there has been a marked increase in attendance at training sessions. Training evaluations demonstrate that staff are responding to the change in delivery of content with an increase in satisfaction levels. The manager reported during interview that long serving staff have been talking about the training during breaks and enjoying the change in delivery.</p>	<p>2017 had a combined 75% attendance rate of all staff members. This was an average of 25% more than all training completed previously in 2017.</p>
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End of the report.