

# Thyme Care Limited - Ripponburn Home and Hospital

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## Introduction

This report records the results of a Provisional 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 Q-Audit 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:

<b>Legal entity:</b>	Thyme Care Limited
<b>Premises audited:</b>	Ripponburn Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 27 January 2021      End date: 28 January 2021
<b>Proposed changes to current services (if any):</b>	Proposed changes to ownership of the service is anticipated to occur on 6th March 2021.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	44



# Executive summary of the audit

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## 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

Ripponburn rest home and hospital (Ripponburn) provides rest home and hospital level care for up to 46 residents. There were 44 residents at the facility on the first day of the audit.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board.

The prospective owners are in the process of completing the requirements to purchase the service and have experience in the health sector.

There are no intentions to change existing service delivery or the environment should the sale of the service be confirmed.

A change of ownership is anticipated to occur on 6th March 2021. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, a general practitioner, and prospective owner's management team.

There is one area identified as requiring improvement relating to documentation of neurological recordings following residents unwitnessed falls.

## 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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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent is practised, and written consent is gained when required. Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents.

Residents are observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

There are policies and procedures about the management of complaints that align with right 10 of the Health and Disability commissioner's code of Health and Disability Consumers Rights.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Ripponburn Holdings Limited is the governing body and is responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned. There are systems in place for monitoring the services provided, including regular reporting by the general manager to the governing body.

The facility is managed by an experienced and qualified general manager who is a registered nurse with aged care experience, and they have been in this position since 2004. The general manager is supported in her roll by a nurse manager who is responsible for the oversight of the clinical services in the facility.

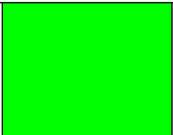
There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented on accident/incident forms. Facility meetings are held where there is reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

There are policies and procedures on human resource management. A mandatory education programme is provided for staff.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice.

Residents information is accurately recorded, securely stored and not accessible to unauthorised persons.

## 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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All stages of service provision were completed by in a timely and competent manner There is an admission package available prior to or on entry to the service. Registered nurses (RNs) are responsible for each stage of service provision, review each resident's needs, outcomes, and care plan goals at least six-monthly. There is Service integration with other members of the health team and

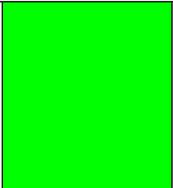
multidisciplinary approach to meet assessed needs and desired outcomes Resident files include medical notes by the GP nursing team and Allied health professionals' documentation.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent care staff responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the GP at least three monthly.

Residents' food preferences and dietary requirements are identified at admission. All meals are cooked on site by a kitchen staff employed by Ripponburn Home and Hospital. Registered dietitian review and approve food Menu. Food, fluid, nutritional needs of residents are provided in line with recognised nutritional guidelines and nutritious snacks available 24 hours a day. There is food control plan in place.

## 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 building has a current building warrant of fitness displayed. There is a reactive and preventative maintenance programme, and this includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Residents bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids, and to allow for care to be provided. Lounges, dining areas, and sitting alcoves are available for residents and their visitors. External areas are accessible, safe and provide shade and seating.

Staff are trained in the use of emergency equipment and supplies and attend regular fire drills. Residents reported a timely staff response to call bells. Security is maintained.

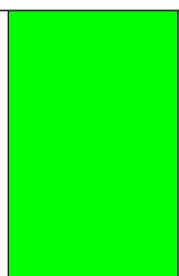
Staff use protective equipment and clothing. Chemicals and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness. Cleaning of the facility is conducted by household staff and monitored.

## 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's 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 at Ripponburn Home and Hospital. A restraint register is maintained, updated every month, there have been two residents on restraint and three enablers during audit days. The restraint coordinator /RN provides support and oversight for enabler and restraint management, Staff interviewed demonstrated a sound understanding of restraint minimisation use and residents monitoring.

## 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 management system are in place to minimise the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. The required policies and procedures are documented. Infection data is collated monthly, analysed, and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## 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)
<b>Standards</b>	0	49	0	1	0	0	0
<b>Criteria</b>	0	99	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	Ripponburn 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 training records.
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make	FA	<p>Policies and procedures guide staff in relation to informed consent and staff interviewed understood the principles and practice of informed consent.</p> <p>The residents' files evidenced documented consents using the organisation's consent form that includes consent for photographs, outings, and collection and sharing of health information. Consent is also obtained on an as-required basis, such as for the influenza vaccinations or sharing of rooms.</p> <p>There was evidence of advanced directives signed by the residents. Residents confirmed they were supported to make choices, and their consent was obtained and respected. Family members also reported they were kept</p>

<p>informed choices and give informed consent.</p>		<p>informed about what was happening with their relative and consulted when treatment changes were being considered.</p> <p>Staff were observed gaining verbal consent for day-to-day care.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. Staff demonstrated understanding of the advocacy service, with contact details for the service readily available at the facility.</p> <p>Posters and brochures related to the advocacy Service were also displayed and available in the facility. Residents are provided with information on the advocacy service as part of the admission process. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>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' family 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>	<p>FA</p>	<p>The 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.</p> <p>The GM is responsible for complaints management.</p> <p>There have been no complaints received from external sources since the previous audit. The GM is the complaints officer. The review of the 2020 complaints register evidenced the required processes were consistently taken, through to an agreed resolution, are documented and completed within the required timeframes. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>During the admission process, new residents and their family are given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service .</p> <p>The Code is displayed in the reception area together with information on advocacy services, how to make a complaint form.</p> <p>Residents and family interviewed were familiar with the Code and the advocacy service. Residents and family stated they would feel comfortable raising issues with staff and management.</p> <p>The prospective owners currently operate a retirement village located in close proximity to Ripponburn.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Staff communicated their knowledge about the needs to maintain resident's privacy and were observed doing so throughout the audit.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and outings, confirmed at residents and family interviews. Residents' care plans include documentation relating to residents' abilities and strategies to maximise independence. Residents' records sampled confirmed that residents' individual cultural, religious, social needs, values, and beliefs were identified, documented, and incorporated into their care plan.</p> <p>The policy on abuse and neglect was understood by staff interviewed, including what to do should there be any signs. Education on abuse and neglect is part of the staff orientation programme and in the mandatory staff education.</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</p>	<p>FA</p>	<p>The service has a Māori Health Plan that guides staff in meeting the needs of the residents who identify as Māori. Any additional cultural support, if required, would be accessed locally, confirmed at diversional therapist interview. At the time of the audit there was one resident who identified as Māori. The review of their clinical file and interview confirmed their individual cultural needs were being met.</p> <p>Family/whanau are able to visit their family members at the facility and are part of the care planning and evaluation care process. Interviews with family confirmed they were informed of their family members changes in condition when this occurred, are invited to residents' meetings, receive newsletter, and are involved in multidisciplinary reviews.</p>

beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The individual preferences, values and beliefs of residents are documented in the care plans reviewed. Residents and family members stated they had been consulted about individual ethnic, cultural, spiritual values, and beliefs, and confirmed that these were respected.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Staff job descriptions and the induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Ripponburn implements policies and procedures which are based on good practice, current legislation and relevant guidelines. The service encourages and promotes good practice through, input from external specialist services and allied health professionals, for example: physiotherapists and podiatrist services.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p>
Standard 1.1.9:	FA	<p>Residents and family members stated they were kept well informed about any changes to their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical</p>

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>reviews. (refer to 1.2.4.3).</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Resident meeting minutes reviewed evidenced relevant information is shared and concerns acted upon in a timely manner.</p> <p>Staff interviewed confirmed the process if access to interpreter services is required on admission to the service. Interpreter services can be accessed via the district health board (DHB) or Interpreting New Zealand when required. Staff reported this is rarely 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>The service is up for sale and the prospective owners Thyme Care Limited commissioned a provisional audit. The prospective owners have an established structure outlined in their business plan(sighted). Thyme Care Limited currently own and manage a local retirement village, Goldenview Village. This facility is currently developing a new 60 bed purpose-built rest home, hospital level and dementia care facility, Goldenview Care. With 48 beds due to open on 1st August 2021 and the final 12 beds in December 2021.</p> <p>The transition plan includes the prospective owners' transition of the running and management of the current service to the new proposed structure. The prospective owner's intention is to retain the current service as it is including all staff. Management changes include the appointment of a new facility manager (FM) and clinical nurse manager (CNM). The proposed FM is currently engaged as a consultant for the development of the new purpose build facility. The planned settlement date is 6 March 2021.</p> <p>The prospective owner intends to manage this service in the same manner as the retirement village and link to the new purpose-built facility Goldenview Care running as "sister facilities". Reporting structures such as key performance indicators such as incident/accidents, wound management, restraint and complaints will be reported by the new FM to the Thyme Care Limited board.</p> <p>The FM will be responsible for the overall management of the service. The FM is a registered nurse (RN) and has experience in management of residential care facilities. Appointment has been confirmed from February 2021.</p> <p>The FM will be supported by a clinical nurse manager (CNM) who will be responsible for the oversight of clinical services. The CNM is an RN who has been employed as a RN in the facility for over 10 years and is currently covering the nurse manager (NM) position while the NM is on leave.</p> <p>Relevant authorities will require notification of the change in personnel by the new prospective owners.</p> <p>Residents, relatives and staff have been notified of the change of ownership; this was confirmed at interviews.</p> <p>The service holds contracts with the district health board and ministry of health for rest home, hospital level care,</p>

		<p>long term support, chronic health conditions (including under 65 years of age) and palliative care.</p> <p>There were 44 residents receiving service on the day of audit. Comprising 15 rest home and 29 residents requiring hospital level care. One resident under the 65 years of age was receiving hospital level care under a chronic health condition contract.</p> <p>The facility does not have any residents under the occupational rights agreements (ORA). There were no boarders at the time of the audit.</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>The prospective owner reported at interview the appointment of the new FM and the CNM. In the absence of the FM, the CNM is delegated to perform this role, with the support from the sister facility Goldenview Care for oversight of management and clinical care.</p> <p>During absences of key clinical staff, the clinical management is overseen by RN on the shift who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</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>Ripponburn currently uses a quality and risk management framework that is documented to guide practice.</p> <p>The service implements policies and procedures to support service delivery, including policies on interRAI. All policies are subjected to reviews as required with policies current. Policies are reviewed by the NM with input from relevant staff and management. Policies are linked to the Health and Disability Sector Standards current and applicable legislation and evidenced-based practice guidelines. Policies are readily available to staff. New and revised policies are presented to staff to read and discussed at staff meetings; this was confirmed at staff interviews. The prospective owner confirmed the existing policies and procedures will remain and reviewed as required and align with Goldenview Care.</p> <p>Service delivery is monitored through complaints, review of incidents/accidents, audit schedule and resident family and staff satisfaction surveys.</p> <p>Facility meetings reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and staff meetings. Staff reported that they are kept informed of quality improvements, such as audit activities. Relevant corrective actions are developed and implemented to address any</p>

		<p>shortfalls.</p> <p>Ripponburn has a risk management programme in place. Health and safety policies and procedures are documented along with hazard management programme. There is evidence of hazard identification forms completed when a hazard was identified and that hazards are addressed, and risks minimised. The Health and safety officer is the NM. The GM 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>	PA Low	<p>Staff understood the adverse event reporting process and were able to describe the importance of reporting near misses. Staff are documenting, unplanned or untoward events on an accident/incident forms and are completed by staff who either witnessed an adverse event or were first respond. The RNs undertake assessments following an accident. An area of improvement relates to documentation of neurological observations following unwitnessed falls.</p> <p>Policy and procedures comply with essential notification reporting, for example health and safety, human resources and infection prevention and control. The GM is aware of situations in which the service would need to report and notify statutory authorities: Including police attending the facilities, unexpected deaths, sentinel events, notifications of a pressure injury, infectious disease outbreaks, and changes in key clinical managers.</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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificated, and practitioners' certificates are current. Current certificates were evidenced for all staff and contractors that require them.</p> <p>The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities, and authority. These were reviewed on staff files along with employment agreements, reference checks, police vetting, first aid certificates and a recent performance appraisal.</p> <p>Staff orientation includes all necessary components relevant to the role. Carer staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Care givers are paired with a senior care giver or a RN until they demonstrate</p>

		<p>competency on specific tasks for example hand hygiene, moving and handling. Staff reported that the orientation process prepared them well for their role.</p> <p>Ripponburn has a documented comprehensive education schedule that covers all the needs of the service provided.</p> <p>There were four RN's that were interRAI competent.</p> <p>The prospective owners confirmed on interview that all existing staff will be retained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Staffing rosters were sighted and one RN is on each shift, which meets the documented rationale for staffing at the service. The facility adjusts staffing levels to meet the changing needs of residents. Carer staff reported there were adequate staff available to complete the work allocated to them.</p> <p>Staff and residents interviewed confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time.</p> <p>The prospective owners confirmed there has been no planning to change the existing roster or staff allocation.</p> <p>The new FM and CNM will be onsite for 40 hours per week.</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>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of residents' records.</p> <p>All resident files are in hard copy and stored in the nurses' station areas. Entries are legible, dated and signed by the relevant staff member including designation. Individual residents' files demonstrate service integration. The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are stored in secure areas. Residents' files are held for the required period before being destroyed.</p> <p>No personal or private resident information was on public display during the audit.</p> <p>The prospective owners intend to maintain an electronic patient management system, that will be linked to key performance indicators such as incidents/accidents.</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 GM, acting nurse manager (ANM) /RN and nursing team are responsible for managing the admission process. Residents enter the service when required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) agency. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. Records sampled confirmed all entry requirements were conducted within the required time frames in a competent and timely manner. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission in respectful manner. 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 coordinated manner, with an escort. There is open communication between all services. At the time of transition appropriate information is provided to the person/facility responsible for the ongoing management of the resident. All referrals are recorded in the progress notes. Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers when required or if the need for other non-urgent services is indicated or requested, Family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the nursing team.</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 system is implemented to ensure that residents receive medicines in a secure and timely manner. Medicine management policies and procedures are adequate to cater for hospital level residents when required. Medications are stored securely in the trolley and locked cupboards. Medication reconciliation is conducted by registered nurses. Medications are reviewed three monthly and as required by the GP. The service uses electronic medication chart. Allergies are clearly indicated, and photos current for easy identification. PRN medication administration reason and outcome have been documented by RN. An annual medication competency is completed for all staff administering medications and medication training records were sighted. A registered nurse was observed administering medicines and complying with required medication protocol guidelines and legislative requirements.</p> <p>There were no residents self-administering medications at the service in the audit days. Staff were aware of self-administration medication policy requirements. Weekly and six-monthly controlled drug stock takes are conducted, and Pharmacist signing in drug control register six monthly control. Monitoring of medication fridge temperatures and medication storage room is conducted, and records were sighted.</p> <p>The previous Audit concern related to medicine management "Audit Corrective Action "has been addressed and</p>

		resolved.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The current food service is satisfactory to accommodate the needs of the residents. Meal services are prepared on site and served in dining rooms. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required. There is a four weekly seasonal rotating menu in use. Diets are modified as required and the cooks confirmed awareness on dietary needs of the residents. Alternative meal options are offered as required. A nutritional profile is developed on admission and reviewed every six months or when there is any significant change. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. Snacks and drinks are available for residents when required.</p> <p>The cook on duty reported feedback is taken from residents on food satisfaction surveys and during meetings with resident and on one-to-one basis. Evidence of resident satisfaction with meals was verified by resident and family interviews, and auditor observation, residents given time to eat their meal in an unhurried approach and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed. Dietitian monitoring and audit report sighted, the menu reviewed by registered dietitian within the last two years The kitchen registered under the food control plan. certificate of Kitchen audit by relevant body valid. Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines.</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</p>	FA	<p>All residents who are declined entry are noted. When a resident is declined entry, family/whanau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider. This is as reported by the acting nurse manager.</p>

organisation, where appropriate.		
<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>Initial assessment tools are used to assess the residents' needs, support requirements and preferences on admission. Nursing assessments and initial care plan are completed within the required time frame on admission, while residents' care plans and interRAI assessments are completed within three weeks according to policy. Activities assessments. and care plans were detailed and included input from the family/whanau, residents, and other health team members as appropriate and timely manner. Additional assessments are completed according to the need and this included pain, behavioural, falls risk, nutritional requirements, continence, skin, and pressure injury assessments. family/whanau and residents expressed satisfaction with the assessment process.</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 are resident focussed, integrated, and provide continuity of service delivery. Assessments were completed in a timely manner. Long term and short- term care plans are developed for acute and long-term needs. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</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>The documented interventions in short term care plans and long-term care plans were sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Clinical supplies are adequate, and the staff confirmed they have access to the supplies and products they needed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	FA	<p>The activities programme is provided by a trained diversional therapist and three activities assistants covers seven days of the week. There are separate planned activities for rest home and hospital level residents. However, all residents are free to join either side activities if desired, and there are other activities that are combined especially the ones provided by external groups or performers and church services. Individual, group activities and regular events are offered. The activities are used to facilitate emotional and physical wellbeing, activities reflected residents' goals, ordinary patterns of life and included normal community activities. Residents and families/whanau</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>were involved in evaluating and improving the programme through residents' meetings, satisfaction surveys and six-monthly multidisciplinary reviews. Residents interviewed confirmed they find the programme satisfactory. The activities on the programme can either be individual or group activities include: Bingo, internal quiz sessions, music, newspaper reading, bowls, church sessions, external entertainment, visits from the day care, and quiz competitions with other service providers, Tai Chi, afternoon tea, care, and friendship sessions where residents go out into the community. The residents were observed participating in a variety of activities on the audit days.</p> <p>There are planned activities and community connections that are suitable for the residents. The DT reported the resident cultural requirements and preferences taken in consideration. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. Activities plans are evaluated every six months, and information integrated in the interRAI assessment. Evidence activities assessment, schedule and related plans have been sighted.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>There was evidence that residents' care plans are personalised and reflect interRAI assessments. Initial care plans were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the RNs six monthly or earlier for any health changes in the resident. Activity plans are evaluated at least every six months and updated when there are any changes. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed and when required, evaluated, closed out when the short term problem has been resolved, or intergraded into the long term plan if not resolved. Family is invited to attend the multidisciplinary review meeting and are consulted in the review process. Written evaluations reviewed, identified if the resident goals had been met or unmet. Ongoing nursing evaluations occur as indicated and are documented in the progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or</p>	<p>FA</p>	<p>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The ANM confirmed that processes are in place to ensure that all referrals are followed up accordingly. General Practitioner (GP) and the nursing team send a referral to seek specialist services assistance form the district health board (DHB). Referrals are followed up on a regular basis by the nursing team or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to the DHB in an ambulance if required.</p>

provided to meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies and procedures in place for the management of waste and hazardous substances.</p> <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Safety data sheets were available. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>Protective clothing and equipment appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff.</p> <p>A hazard register and maintenance plan are in place.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed.</p> <p>There is a preventative and reactive maintenance programme in place. Staff are aware of the processes of reactive maintenance requests to ensure timely repairs are conducted, confirmed at staff and maintenance interviews.</p> <p>The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment.</p> <p>The facilities were observed to be in good condition, light, well ventilated, appropriate and suitable for the needs of residents, with safe external areas. Residents can walk around freely throughout the facility and grounds. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>The facility has two resident vans that have current registration and warrant of fitness.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are</p>	FA	<p>Bedrooms throughout the facility have a handbasin. Two bedrooms have full ensuites. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. The fixtures fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Communal toilets and showers have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided in the toilet/shower</p>

<p>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>areas, and other equipment/accessories are available to promote resident independence.</p> <p>Hot water temperatures are monitored monthly. When there have been hot water temperatures above the recommended safe temperature, action is taken and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.</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. The hospital wing has six double rooms, shared agreements have been completed. The rest home has two double rooms that can be used for married couples, currently used as single accommodation rooms.</p> <p>Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheelchairs and mobility scooters when required.</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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents were observed moving freely within these areas.</p> <p>Residents can access areas for privacy, if required. 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>Cleaning and laundry policies and procedures are available.</p> <p>Cleaning chemicals are securely stored in locked cupboards and are labelled. Interview with the laundry staff member confirmed residents' personal clothes are washed on site separate to other laundry. The laundry person described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.</p> <p>The household staff member described the cleaning processes and the use of chemicals for cleaning purposes. There are safe and secure storage areas for cleaning equipment and chemicals and staff have access to these areas as required. Sluice rooms are available for the disposal of soiled water/waste. Handwashing facilities are available throughout the facility with alcohol gels in various locations.</p> <p>Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</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 are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The fire evacuation scheme for the facility has been approved by the New Zealand Fire Services. The trial evacuations are conducted six-monthly. The last fire evacuation was conducted in November 2020.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, and gas BBQ's were sighted and meet the requirements for the number of residents. A water storage tank is located on the complex. 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 residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time by staff.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and a small handbasin.</p> <p>Individual bedrooms and communal areas are heated by adjustable radiators. The maintenance person interviewed ensures the centralised diesel boiler is running smoothly and that appropriate checks are performed. On the days of audit, the indoor temperature was comfortable.</p> <p>Residents and families confirmed the facilities are maintained at a comfortable temperature during the summer and</p>

light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		winter months. An area outside the building is available for residents who smoke.
<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 an environment that minimises the risk of infection to residents, staff, and visitors by implementing an appropriate infection prevention and control programme. The role of the infection control coordinator has access to external specialist advice from the GP practice and DHB infection control specialists when required. The infection control programme is approved and reviewed annually. Infection rates are discussed at monthly staff and health and safety meetings. Staff are made aware of new infections through daily handovers on each shift and reporting, IC Poster displayed. There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme and knew that they are required to report residents who are suspected of having infections to the RNs promptly. Staff were able to identify the importance of hand hygiene and using standard precautions.</p> <p>Covid-19 information is shared and accessible to all staff to read. Residents are closely monitored for any signs and symptoms. Personal protective equipment (PPE) was sighted.</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 prevention and control coordinator (ICC) has appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control. Additional support and information are accessed from the infection control team at the DHB and the GP as required. The infection control coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection</p>
Standard 3.3: Policies	FA	Ripponburn Home and Hospital infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies documented, reviewed, and included

<p>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>		<p>appropriate referencing. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. The 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.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. The infection control coordinator completed infection prevention and control online training. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets current best practice guidelines.</p> <p>External contact resources included the GP, laboratories, and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. IPC education is conducted to family/whanau and residents who can still comprehend and follow basic instructions.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives,</p>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly, includes infections of the urinary tract, skin, eye, the upper and lower respiratory tract, gastro-intestinal and multi resistant organisms. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports.</p> <p>The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are</p>

<p>priorities, and methods that have been specified in the infection control programme.</p>		<p>prescribed to combat the infection.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The use of restraint is actively minimised, and the restraint coordinator described how alternative methods are discussed with staff and family members. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. The restraint coordinator reported that access to advocacy is provided if requested and all processes ensure dignity and privacy are respected. The restraint register is maintained, updated every month, and reviewed at each restraint approval group meeting. there have been two residents on restraint and three enablers during audit days The register was reviewed and contained all residents currently using a restraint, and enough information to provide an auditable record. Staff have received training in restraint minimisation, falls prevention and challenging behaviours. Ripponburn Home and Hospital's policy and procedures on restraint are discussed with staff as part of orientation programme, documentation was sighted Interviewed staff understood that the use of restraint is to be minimised and how to maintain safety when in use. Restrictive methods of restraint were used for the least amount of time as confirmed in the records reviewed and interviews with staff.</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 organisation's 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. The restraint coordinator/RN provides support and oversight for enabler and restraint management and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. A restraint register is maintained, updated every month, and reviewed at each restraint approval group meeting. Staff interviewed are aware that an enabler must be the least restrictive and used voluntarily at a resident's request. The restraint can be used as a last resort when all alternatives have been explored and that this would trigger a referral for assessment. The restraint in use bed rails have been approved by the Restraint minimisation team. The assessment forms have been completed, approvals for restraint use taken from the Quality and resident safety team include General manager, ACM , restraint coordinator RN, GP signed on the restraint in use as evidenced by the medical notes and records sighted. EPOA have signed consent for restraint use. (refer to Tracer 1.3.3).</p> <p>Staff interviewed demonstrated understanding of restraint and enabler use, and care of resident's with restraint. Restraints is part of orientation and training is provided annually or as necessary.</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>Review of residents' file showed required assessment prior to restraint use and on regular intervals. Risks related to the use of restraint have been identified, falls risk assessment identified high risk for falls. Pain, continence, dietary, skin, and behavioural assessment conducted. The assessment forms have been completed, signed by the restraint coordinator /RN. Approvals taken from the Quality and resident safety team include General manager, acting nurse manager, restraint coordinator RN, GP reviewed and signed on the restraint in use as evidenced by the medical notes and records sighted. EPOA have signed fully completed consent for restraint use. The restraint use evaluated in the care plan, and interRAI review. Evaluation covers all requirements as per policy include options to eliminate use. Staff interviews and staff records given on restraint minimisation and safe practice (RMSP) enabler use and prevention de-escalation technique.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Ripponburn Hospital and Home has a commitment to provide quality services for residents in a safe environment and work to minimise the use of restraint. The restraint coordinator /RN Qualified and has education and training in restraint management and use. The use of restraint at the service is actively minimised, and the restraint coordinator described approved restraint is only applied as a last resort, with the least amount of force and how alternative methods are discussed with staff and family members. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. The restraint coordinator reported that access to advocacy is provided if requested and all processes ensure dignity and privacy are respected. The restraint register is maintained, updated every month, and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint, and enough information to provide an auditable record. Staff have received training in restraint minimisation, falls prevention and challenging behaviours. Interviewed staff understood that the use of restraint is to be minimised and how to maintain safety when in use. restrictive methods of restraint were used and for the least amount of time as confirmed in the records reviewed and interviews with staff. The bed rails restraint used for safety of residents due to frequent falls, it is used when resident in bed only, Crash mattress and sensor matt placed on floor and protection applied on the rails for resident safety, as described by the Restraint Coordinator/RN. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints was reviewed and evaluated during care plan, interRAI reviews, three- and six-monthly restraint evaluations, and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of this standard, including future options to eliminate use, the impact and outcomes achieved. Restraint audits were completed, and corrective action plans were implemented where 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 quality improvement committee conduct a three-monthly review of all restraint use which includes all the requirements of this standard, individual restraint use is reported in the quality and staff meetings periodically. Minutes of meetings reviewed confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered and the effectiveness of the restraint in use.</p> <p>Restraint use competency assessments for staff were completed annually, current restraint competencies were sighted in reviewed staff files. Restraint use internal audits also informed these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated as reported by the restraint coordinator during interview.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Ripponburn has policies and procedures that guide staff as to the requirements when reporting an unwitnessed fall of a resident.</p> <p>On review of reported unwitnessed falls for the month of January 2021, it was noted of the 7 reported only 3 had neurological observations completed. On review of previous months incidents, it noted the same inconsistency of neurological observations completed. Discussion with the GM and relieving NM confirmed neurological recordings were inconsistently completed.</p>	<p>Incident/accident records for residents who had unwitnessed falls, did not consistently evidence neurological observations occurred over 24 hours, as per policy.</p>	<p>Ensure incident/accidents records for residents who experience unwitnessed falls consistently record neurological observations as per policy.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

No data to display
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End of the report.