

# Ambridge Rose Manor Limited - Ambridge Rose Manor

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## 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 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>	Ambridge Rose Manor Limited
<b>Premises audited:</b>	Ambridge Rose Manor
<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: 30 March 2021 End date: 31 March 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	101

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

## General overview of the audit

Ambridge Rose Manor provides rest home and hospital level care for up to 104 residents. The service is operated by Ambridge Rose Manor Limited and is managed by a management team consisting of the two directors one of whom is the chief executive officer, an owner/manager, chief operating officer, a clinical nurse manager, a clinical lead and a registered nurse supervisor and administration staff. 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 records, observations and interviews with residents, family members, management, staff, contracted allied health providers and a general practitioner.

This audit has resulted in two continuous improvements for an activities programme quality initiative and restraint minimisation and safe practice. There were no areas identified as requiring improvement.

## 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 (the Code) and these are respected. Services and care provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. There was no evidence of abuse, neglect or discrimination.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent and act on any advance directives.

Residents who identify as Māori, or other cultures, have their needs met in a manner that respects their individual cultural values and beliefs.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

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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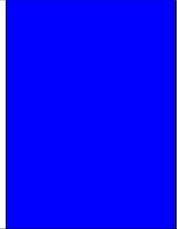
Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services occurs and reports are provided by the quality and clinical team to the governing body. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identification of 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 performance review. Staff levels and skill mix meet the changing needs of residents.

There was no information of a personal nature on display. There is secure storage of records.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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The Registered Nurses are responsible for the development of care plans with input from residents, staff, and family member representatives. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems as they arise. Files reviewed demonstrated that the care provided and needs of the residents are reviewed and evaluated.

The planned activities programme provides residents with a variety of individual and group activities and maintains their links with the community.

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 or when required.

The food service is provided onsite and caters for residents providing nutritious meals, snacks and fluids in line with recognised nutritional guidelines. Residents who require special or modified meals are reliably catered for. A food control plan was 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 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 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.		All standards applicable to this service fully attained with some standards exceeded.
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A senior registered nurse is the restraint coordinator. The organisation has policies and procedures that support the minimisation of restraint. Ongoing restraint and challenging behaviour training are provided. There were 12 restraints and 4 enablers in use at the time of the audit. A quality improvement study was conducted with the main objective being to reduce the number of restraints used in the facility. This project was achieved.

## 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 control program in place aims to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. 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 and is carried out as specified in the infection control programme

## 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>	2	48	0	0	0	0	0
<b>Criteria</b>	2	99	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the in-service and online education programmes. Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents reported that they understand their rights. The relatives reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give</p>	FA	<p>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where applicable, this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. An advance directive and advance care plan are</p>

informed consent.		<p>used to enable residents to choose and make decisions related to end of life care. Three of 10 files reviewed contained signed advance care plans that identify residents' wishes and meet legislative requirements. This is being encouraged by the registered nurses interviewed.</p> <p>Residents and family/whanau (where appropriate) are included in care decisions.</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>Advocacy information is available in brochure format at the entrance to the facility. Residents and family/whanau are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The staff interviewed reported knowledge of residents' rights and advocacy services.</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 reported they are supported to be able to remain in contact with the community through outings and walks. Policy includes procedures to be undertaken to assist residents to access community services and a mobility van is available. The activities programme involves linking with other aged care providers and support services. Visitors are welcome to visit residents anytime or by arrangement with the clinical nurse manager.</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 complaints/compliments 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 complaints register reviewed showed that five minor complaints have been received over the last six months and the actions taken, through to an agreed resolution, are clearly documented and completed within the timeframes. Action plans showed any required follow-up and improvements have been made where possible. The CEO is responsible for complaints management and follow-up. Any clinical complaints are referred to the clinical nurse manager and/or clinical lead. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been two health and disability commissioner complaints received since the previous audit and both were referred to the nationwide health and disability advocacy service and were effectively closed out. No additional complaints were received from other external sources since the previous audit.</p>
Standard 1.1.2: Consumer	FA	Policy details that staff will be provided with training on the Code and that residents will be provided with

<p>Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>the Code information on entry to the service. Copy of the Code and other information related to rights are in the residents' rooms and displayed throughout the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families, as confirmed by interview with the clinical staff. Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Residents and family/whanau report that the residents are addressed in a respectful manner that upholds their rights. Nationwide health and disability advocacy service details are provided in the information provided to all residents on admission.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of resident related information. The residents interviewed and files reviewed evidenced that the individual values and beliefs of the residents are respected. There were no concerns expressed by the residents and family/whānau about abuse or neglect. Staff interviewed reported knowledge of residents' rights and understand dignity, respect and what to do if they suspected the resident was at risk of abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery and decision making is sought if applicable. The in-service education programme includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whanau. Whanau are welcome to visit anytime they wish with consent of the resident.</p> <p>On the day of audit there are two residents who identify as Maori and three staff members. The clinical staff reported that there are no known barriers to Maori accessing the services. A kaumatua is available for this service and room blessings can be arranged anytime required and advice sought on any cultural issues if needed.</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</p>	<p>FA</p>	<p>The cultural and/or spiritual needs of the residents are provided for in consultation with the resident and family as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The lifestyle plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of</p>

and respect their ethnic, cultural, spiritual values, and beliefs.		<p>the resident.</p> <p>Residents reported that their individual cultural needs, values and beliefs are met. Staff confirmed the need to respect the individual needs of residents.</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/whanau reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. 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>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals. The service has access and support from visiting specialist nurses, palliative services and mental health teams. Residents and relatives satisfaction surveys evidenced overall satisfaction with the quality of the care and services provided.</p> <p>The service introduced an electronic nursing/resident records management system over ten years ago and this is well embedded into the organisation.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</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/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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to communicate effectively in English. There are communication strategies in place for residents with cognitive impairment or who have non-verbal means of communication.</p>
Standard 1.2.1: Governance	FA	The business plan dated 2021 to 2026 was reviewed. Strategies have been reviewed annually and

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>according to timelines documented. When achieved the objectives are crossed off, dated and signed off by the chief executive officer (CEO) and/or the chief operating officer (COO). The business plan outlines the purpose values, scope, direction and goals of the organisation. The organisations values were displayed in all service areas throughout the facility. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly reports from the clinical nurse manager (CNM) and COO showed adequate information to monitor performance is reported including occupancy, financial performance, emerging risks and issues, quality (clinical) indicators (see standard 1.2.3 Quality and Risk Management), results of internal audits and variations to expected service delivery.</p> <p>The CEO and COO work closely together and are supported by the other seven members of the management team. The COO is responsible for the day to day operation of the facility, including the business management responsibility for the pay roll for all staff employed in the organisation. The clinical nurse manager, the clinical lead and the registered nurse supervisor are responsible for all clinical aspects of service delivery.</p> <p>Responsibilities and accountabilities are defined in the job descriptions and individual employment agreements reviewed. The CEO and COO interviewed confirmed knowledge of the sector, regulatory and reporting requirements and both maintain currency through attending aged care related seminars and conferences and other relevant training suitable for the positions.</p> <p>The service holds contracts with Counties Manukau District Health Board (CMDHB) for age related residential care rest home and hospital level care including respite care, long term support-chronic health conditions (LTSCH) for rest home and hospital level care. On the day of the audit 101 residents were receiving services; eight (8) rest home level and 89 hospital level care and nil respite care. Three LTSCH hospital level residents and one LTSCH rest home level care resident were also receiving care. There were three unoccupied rooms on the day 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>	<p>FA</p>	<p>When the COO is absent, the clinical nurse manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a recently employed registered nurse clinical lead who is experienced in the sector and with interRAI assessments. Also, additional support is available from the registered nurse supervisor and other senior registered nurses. The CEO would also be available for advice if required. 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>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, regular resident meetings, monitoring of clinical indicators, incidents including accidents, infections, pressure injuries, falls (with and without injury) staff incidents and health and safety issues.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators. There is monthly reporting to the COO. From the monthly reports, graphs and summaries of the facility's data are developed against each of the individual clinical indicators by the clinical nurse manager. These reports are discussed at the monthly quality and risk/infection prevention and control/health and safety meetings (Q&amp;R/IPC/H&amp;S), at the registered nurse (RN) meetings, and at the staff meetings. The results and graphs are further displayed on the staff room notice board. Staff interviewed reported their involvement in these different meetings. Regular internal audit activities occur each month against a calendar of audits. The results are discussed at the Q&amp;R/IPC/H&amp;S meetings. Relevant corrective actions are also discussed and were noted in meeting minutes. Meetings with residents are held regularly and they are able to raise and discuss any concerns or issues they have during these meetings.</p> <p>The organisation's system of monitoring corrective actions which result from internal audits required formal reporting through the COO and involvement of the clinical nurse manager/clinical lead if needed. The COO interviewed was aware of any areas identified and described the actions taken to address them. The most recent Q&amp;R/IPC/H&amp;S meeting minutes were sighted and recorded discussion of the last internal audit and the actions to be taken.</p> <p>Policies reviewed cover all necessary aspects of service delivery and contractual requirements, including reference to the interRAI assessments and other contracts held by this facility. 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 any obsolete documents. A quality consultant provides all policy updates and policies requiring review and update. The CEO is responsible for signing off any documented changes to policies and procedures and/or any new policies developed for implementation.</p> <p>The COO described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The organisation has policies and procedures which provide guidance on 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</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported by the clinical nurse manager. An electronic system has been developed and implemented for any incidents/accidents</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>reported. The information is entered into the electronic system from the hardcopy incident record, then the form is scanned into the electronic individual resident's record by the clinical nurse manager. A selection of these reports was sighted for 2020/2021. Staff understood their responsibilities for reporting and recording adverse events.</p> <p>The COO described essential notification reporting requirements, including for pressure injuries and infection outbreaks. Examples of notifications of significant events made to the Ministry of Health, since the previous audit were reviewed. The facility manager was well informed of statutory and/or regulatory obligations to report. There have been three Section 31 notices completed and sent to Ministry of Health (MoH) HealthCERT since the previous audit. The service's open disclosure policy was sighted.</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 are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of staff records 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. New staff members reported, and files reviewed confirmed, that orientation has been completed as required. Staff reported that their orientation prepared them for their role. Staff records reviewed showed documentation of completed orientation and a performance review after three months and then annually thereafter.</p> <p>Continuing education is planned at the facility annually with mandatory training requirements being covered in addition to any site-specific needs. The education assessor works between two facilities within the organisation, assists with the development of the annual education plan for staff and is available for advice. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with Counties Manukau District Health Board (CMDHB). There are seventy health care assistants and thirty seven (37) have completed level 4, four (4) level 3, six (6) level 2 and 23 are yet to complete the training. There are five trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments.</p> <p>Documentation and records reviewed showed that key competencies (medication, restraint, first aid, infection prevention and control (including Covid 19 precautions and hand hygiene) have been addressed for the majority of staff. All staff education records are accessible on the spread sheet maintained electronically. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>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 (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a six week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Rosters reviewed are documented for clinical and non-clinical duties. The executive chef completes the kitchen rosters. Bureau staff are contracted at this facility if needed and if contracted are orientated to the service. InterRAI data is used to guide staffing decisions. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage for the hospital level residents.</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>All necessary demographic, personal, clinical and health information was completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information entered into the electronic database.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Admission information packs for Ambridge Rose Manor are provided for families and residents prior to admission or on entry to the service. The policy has all the required aspects of management of resident admission. All resident files reviewed had the appropriate needs assessments prior to admission to the service. Screening processes are clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. The enduring power of attorney (EPOA) of each resident was in place in files sampled. Admission agreements reflect all the contractual requirements. Families and residents reported that the admission agreements were discussed with them in detail. Details of the services location and hours, how the service is accessed and the process if a resident requires a change in the care provided, is also included under enquiries and entry.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort /family member as appropriate. There is documented process in place and open communication between all services, the resident, and the family. At the time of transition appropriate information is provided to the person/facility responsible for the ongoing management of the resident. The service uses the DHB's</p>

<p>planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>(yellow envelope) system which contains all information about the resident, family/representative details and resuscitation status and/or copies of the enduring power of attorney (EPOA) details if needed. Ambulance transport is arranged to facilitate the transfer of residents to and from acute care services. All referrals are recorded in the progress notes.</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 that meets current legislation, protocols, and guidelines. An electronic management system is used in administration, reviewing, and e-prescribing. The service uses a pre-packed robust medication system. All medication packs are checked by the RN on delivery against medication charts every month. Medication reconciliation is conducted by registered nurses. Medicines held in stock are checked every month and any expired medicines are returned to the pharmacy promptly. GP conducts three monthly reviews of medication charts sighted.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly checks and six-monthly stock checks by the contracted pharmacist. Medication is safely stored in locked cupboards and drug trolley. Fridge temperature and room temperature are checked and recorded. There were no expired medications on site. A competent health care assistant was observed administering medication correctly. All staff who administer medicines were assessed as competent and evidence was sighted. There are no residents who self-administer medications at the service on the audit days. Self-administration policy is in place for use when required.</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>Executive Chef oversees the procurement of food, management of the kitchen and dietary services assisted by cook and kitchen staff. The kitchen is adequately equipped. All meals are cooked on site, meals are served at separate dining room areas from hot boxes. The temperature of the food is checked before serving. On the day of audit meals were observed to be hot and well presented</p> <p>Seasonal menu in place, the menu has been reviewed by registered dietitian, recommendations raised have been addressed and action taken. The nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The residents' weights are monitored monthly, and supplements are provided to residents with identified weight loss issues (refer tracer 1.3.3.3). Snacks and drinks are available for residents who wake up during the night or over the 24-hour period. The personal food preferences, Cultural choice, and 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. Evidence of resident satisfaction with meals was verified by resident and family interviews, if any areas of dissatisfaction are received these are responded to and</p>

		<p>action is taken as confirmed by staff.</p> <p>There is a kitchen manual and range of policies and procedures to safely manage the kitchen and meal services. Checking of fridge and freezer temperature, additional walk-in fridge and freezer, and kitchen inspection is done, records were sighted. The kitchen was observed to be clean and tidy, food pending to be served labelled, and food items stored in the fridge with current dates and labels. No expired food items were in stock. The kitchen Food safety handling training program, and a valid food safety plan certificate was sighted and displayed in the kitchen.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>When a consumer's entry to the service is declined, the resident/whanau are referred to the referrer to ensure that the resident is admitted to the appropriate level of care provider. The reason for declining entry is communicated to the referrer, consumer and their family or advocate in a timely and compassionate manner, assistance given to provide the consumer and their family with other options for alternative health care arrangements or residential services as confirmed by the clinical nurse manager interviewed.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Nursing assessments are completed within the required time frame on admission while residents' care plans and interRAI assessments are completed within three weeks according to policy. Assessments from interRAI integrated in the care plans, were detailed, and included input from the family/whanau, residents, and other health team members as appropriate. Additional assessments are completed according to the need and these included pains, behavioural, falls risk, nutritional requirements, continence status, skin, and pressure assessments. Monitoring of weight, blood sugar levels (BSL) and vital signs observed monthly and frequently if needed. The nursing staff utilised standardised risk assessment tools on admission. In interviews conducted, 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</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</p>

continuity of service delivery.		confirmed care delivery and support is consistent with their expectations and plan of care.
<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 the long-term care plans 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, suited to the levels of care provided and in accordance with the residents' needs, 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 consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>The activities team provide activities across the rest home section and hospital. The two activities assistants cover all week, Care assistants trained to provide activities on weekend. The Diversional therapist from other branch has oversight on activities provided, this arrangement as temporary plan, until new diversional therapist joins the service as reported by the clinic manager. Group and one to one sessions are also scheduled for residents.</p> <p>The planned activities programme provides residents with a variety of individual and group activities and maintains their links with the community. The activities programme is displayed on a calendar sighted, activities include music, movies, church service, Chinese group activities, dancing and walk and talk sessions. Cultural Maori festival, Crafts of Matiriki, Maori songs and music instruments and treaty of Waitangi sessions provided by a Maori resident.</p> <p>Residents' files sampled reflect their preferred activities, these are evaluated every six months or as when necessary. 24-hour activities are addressed in long-term care plans to manage residents with behaviours of concern. Residents' activities information form is completed in consultation with the family during the admission process. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.</p> <p>A quality initiative 'Aged Connect – Reaching out to Families" was initiated by management 10 July 2020 by the CEO. This was reflective of both a quality and activities initiative which once implemented provided a new platform after two lockdowns to communicate effectively with resident's families/representatives and in addition this was an opportunity to showcase the organisations activities programme and highlight the participation of the residents. A continuous improvement was awarded for this initiative which was over and above a full attainment.</p>
Standard 1.3.8: Evaluation	FA	Residents' long-term care plans, interRAI assessments and activity plans are evaluated at least every six

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>months and updated when there are any changes. Resident care is evaluated on each shift and reported in the electronic progress notes and if any change is noted, it is reported to the nursing team. Family/whanau, residents and staff are consulted in the review process. The evaluations document how the resident is progressing towards meeting their goals and responses to interventions. Wound care plan evaluated and documented. Short term care plans are developed when needed, signed, and closed out when the short-term problem has resolved, or if not resolved integrated in long term plan toward meeting the desired outcome.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers when required. If the need for other non-urgent services is indicated or requested, the GP and the nursing team sends a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses or the GP. Acute or urgent referrals are attended to and the resident transferred to the public hospital in an ambulance if required. The service utilises a standard referral form when referring residents to other service providers, the resident and the family are kept informed of the referral process, as verified by documentation and interviews.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed as necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant education and training for staff. Material data sheets were readily available where chemicals are used and stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. A spill kit is available.</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</p>	<p>FA</p>	<p>The building warrant of fitness was displayed at reception and the expiry date was 26 January 2022.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and are maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current and confirmed in documentation reviewed, interviews with maintenance personal and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p>

purpose.		External areas are safely maintained and are appropriate to the resident groups and setting. Residents confirmed they know the processes they should follow if any repairs or maintenance are required, and any requests are appropriately actioned and that they are happy with the environment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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.	FA	There are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. The service is divided into six wings. Each wing has separate toilets and showers that are large in size and accessible. The bathrooms are adequate to meet the needs of eighteen (18) residents in each wing. There is a hand basin in each individual resident's room. Some of the resident's rooms have their own toilet and vanity unit available. Privacy is maintained. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Visitor/staff toilets are available throughout the facility in each service area.
Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provided single accommodation. There are no shared rooms available. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. There are six lounges/dining rooms available throughout the facility. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and	FA	Laundry is undertaken on site in a dedicated laundry. Laundry staff cover seven days a week and staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. All equipment and resources were available, and a monitoring programme was evident and explained by the staff and maintenance personal. Residents interviewed reported the laundry is managed

<p>laundry services appropriate to the setting in which the service is being provided.</p>		<p>well and their clothes are returned in a timely manner.</p> <p>There is a designated cleaning team who have received appropriate training. Product data sheets are provided and material data sheets are accessible. Training is provided by a contracted service provider. Chemicals were stored in a lockable cupboard and were in labelled containers. The cleaning trolleys when not in use are stored in a locked room with key pad access. Cleaning and laundry processes are monitored through the internal audit programme and by the product service provider.</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 procedures 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 another emergency. The current fire evacuation plan was approved 27 June 2012 by the New Zealand Fire Service. A trial fire evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent being the 6 November 2020. The staff receive training as part of the orientation process. Staff interviewed confirmed their awareness of the emergency procedures and education is provided by the health and safety representative and management.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas barbeques were sighted and meet the requirements for the number of residents at this facility and meet the local council regulations. Water storage tanks are located in the complex, and a generator for power supply can be accessed as needed. Oxygen cylinders are also available to support residents if needed. Emergency lighting is available and is regularly tested. Checklists are developed and implemented. Regular three monthly checks of all resources occurs and is recorded by the CEO. Emergency kits are available in the six wings of the facility. First aid supplies are accessible in all service areas. A pandemic storage inventory was reviewed last on 11 March 2021 to ensure adequate supplies are on hand at all times in view of the current Covid 19 international and national pandemic.</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. The display board is in the corridor and at the nurse's stations. External entrance doors and windows are locked at a pre-determined time and staff recheck on the night shift at the commencement of their shift. Closed system security cameras have recently been upgraded and backup is available. Signage is visible. There is an automatic access control system for the entrance gates after 8pm and staff can access with a swipe card. Education is provided to staff on the security reporting system in place.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents` rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Ceiling heating is provided throughout the facility inclusive of each individual resident`s rooms and the lounge areas. Residents have a temperature thermostat control in each individual room and 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>	<p>FA</p>	<p>Ambridge Rose Manor has implemented an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The infection control management is appropriate to the size and the scope of the service. The programme is guided by a comprehensive and current infection control manual, with input from specialist services. The infection control programme and manual are reviewed annually. Infection control matters reports including surveillance results, are reported monthly to the management team, and tabled at the quality improvement committee meeting. There is a notice at the main entrance to the facility requesting anyone who is or has been unwell in the past 48 hours with an infectious condition, not to enter the facility. 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 responsibilities. Residents and staff were offered the influenza vaccine through the GP</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control program is in place to minimise the risk of infection to residents, visitors and other service providers The Infection control coordinator RN has appropriate skills, knowledge, and qualifications for the role. The ICC has completed external training in infection prevention and control and attended relevant infection control study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the local DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents` records and diagnostic results to ensure timely treatment and resolution of any infections. The ICC and interviewed staff 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</p>	<p>FA</p>	<p>Ambridge Rose Manor infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed and included appropriate referencing. Hand washing and sanitiser dispensers were readily available around the facility.</p> <p>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</p>

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.		use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education on infection prevention and control is conducted by the RN Infection control coordinator. The infection control coordinator completed infection prevention and control training to keep their knowledge current. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets current best practice and guidelines. Infection control educational posters displayed all around the facility. External contact resources included the GP, laboratories, and resources from the DHB. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed by the clinical nurse manager and the ICC 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. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, respectively. Infection surveillance data is gathered and presented in a monthly report benchmarked internally with previous data. This data is collated using defined surveillance criteria such as urinary tract infection, wound infection and skin infections. Trends identified (if any) are reported along with results and any recommendations to the clinical team and staff. Reports and data charts sighted,
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The RN/restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organization's policies, procedures, practice, and her role and responsibilities. The RN and staff have been orientated on the restraint minimisation policy. The staff interviewed reported 12 restraints and four enablers in place on the day of the audit. The approved restraints used at the facility included bed side rails, a chair recliner, and lap belts. Enablers are used voluntarily at resident/ family request; the number of restraints have been decreased from last year

		as per records sighted.
<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>	FA	<p>There are policies and procedures on restraint and enabler use, written information for residents and families on restraint and enabler use sighted. Clinical team in place review and approve request for placing resident on restraint or enabler. Approvals taken from the clinical team include clinical manager, nurse clinical leader, restraint coordinator RN, GP signed on the restraint in use as evidenced by GP interviewed and records sighted. EPOAs have signed consent for restraint and enabler use. A 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.</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>	FA	<p>The restraint coordinator described that restraint can be used as a last resort when all alternatives have been explored and that this would trigger a referral for assessment. The GP reviewed the restraint use and documented in the Medication chart. Assessment is conducted prior to restraint use to include any potential risks, Falls risk assessment, any behavioural challenges, nutritional and alternative interventions such as diversional therapist activities are clearly documented. The assessment forms have been completed in the sample of resident records reviewed. Restraint is part of orientation and training is provided annually or as necessary. Staff orientation and training on de-escalation intervention and behavioural challenges management is provided annually. Staff interviewed showed a good understanding of restraint and enabler use, and care of resident with restraints.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<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 RN/restraint coordinator has the qualification and training in restraints and enablers use. Staff interviewed are aware that an enabler must be the least restrictive measure and used voluntarily at a resident's request. Restraint is used as a last resort when all alternatives have been explored and that this would trigger a referral for assessment. The restraints in use such as bed rails, lap belts have been approved by the restraint minimisation team. The bed rails are only used when the resident is in bed. The bed rails currently used are for safety reasons such as a resident having frequent falls. A falls assessment, nutritional, behaviour and risk assessments are also completed as described by the Restraint Coordinator/RN</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. The evaluation followed the policies and procedures, and covers all requirements of this standard, including future options to eliminate use. Restraint audits were completed, and corrective action plans were implemented where required. Reviews of resident with restraint use include the monitoring of effect on resident and outcome and any relevant incidents reported, Restraint use competency assessments for staff were completed annually, current restraint competencies were sighted in reviewed staff files. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</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>CI</p>	<p>The clinical improvement committee conduct a 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 held three monthly. 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. Restraint use monitoring and internal audits also informed these meetings. Any changes to policies, guidelines, education, and processes are implemented if indicated as reported by the restraint coordinator in the interview conducted. Evidence of increased restraint monitoring along with additional education provided to staff, and monthly quality reviews resulted in a reduction of the number of restraints used and sighted. A continuous improvement has been attained for the outcome of this initiative which has already resulted in a positive decrease in the use of restraints. Currently at the time of this audit there are 12 residents compared with 17 recorded last February 2020 using a form of restraint.</p>

## Specific results for criterion where corrective actions are required

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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
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## 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, 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 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The goal to source and establish a secure platform for resident information to be shared with families in ‘Real Time’. This could include photos, birthday messages, event management and feedback especially during the Covid 19 pandemic lockdown experienced in 2020 and in February 2021. This issue was raised 10 February 2020 by the CEO at the management meeting with the idea to investigate what software was available on the market for this purpose noting that it had to be a secure and resident/family members needed to opt in. Over March 2020 this proposed software was discussed and the new software was to be reviewed regarding costs and server hosting before implementation. April this was discussed with internet provider and the system was set up with individual logins. The management team reviewed all residents’ records to determine which families gave permission/consent for the photos and marketing strategies. A list was established of residents’ families. The</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis process of this quality initiative relating to activities and interaction with residents and families in ‘Real Time” was very successful. The aim of this quality improvement project undertaken was to enhance and improve the quality of contact with resident family members in a difficult time, and ongoing by providing reassurance and peace of mind that loved ones were being cared for and supported with diversional therapy. In addition to this families experienced a reduction in feelings of guilt at placing their loved one into residential care, be reinforcing positive aspects of resident life at Ambridge rose Manor, highlighting residents’ participation in</p>

		<p>system was tested on the 24 April 2020 and launched five days later by sending out event messages. The activities team were trained on how to use the system and how to upload the photographs. This was reviewed and discussed with the activities team and there was lots of positive feedback received from families and residents. The system continues to work effectively and all activities notices and events in the calendar are published. This process/system is going to be rolled out to the other two services in the organisation over the coming months.</p>	<p>the activities programme which is full of variety and interests for all residents. The evaluation of this project provided positive comments and multiple compliments from residents' families and residents as well. Families interviewed spoke highly of the initiative and the activities programme provided at Ambridge Rose Manor. No negative comments were received. The programme is ongoing and is proving to be very successful for the residents.</p>
<p>Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are</p>	<p>CI</p>	<p>The clinical team conducted a quality improvement study and developed objectives to reduce the number of restraints used in the facility. A target/aim was set to reduce restraint use by 10% by March 2021 and to further review the situation in June 2021. The restraint minimisation and safe practice programme December 2020 audit evidenced an outcome of 16 residents being restrained at the time. This number had minimally changed from one year ago. Staff discussed this outcome at great length as staff caring for vulnerable persons and knowing that restraint should only be the last step in promoting safety for residents. The meeting minutes were reviewed, and an action plan was developed and implemented to decrease restraint use if possible, with a goal of March 2021. Each individual resident using a form of restraint was reassessed. Additional sensor mats were purchased, and low beds and other safe equipment choices were utilised. Monitoring of residents using a restraint was increased and this was evidenced in the electronic nursing care system in place. Monthly graphs illustrated the progress over all six wings in the facility. The graphs reviewed evidenced residents using a restraint from December to March 2021. Families and residents were kept well informed of the project. The outstanding results were reported to the management team.</p>	<p>The objective of the quality initiative was to reduce the use of restraint through the implementation of alternatives to restraint and the aim is for the facility to be a restraint free environment. This was initiated as a result of the restraint audit completed in December 2020 when 16 residents were on the restraint register as using a restraint.</p> <p>All residents using a restraint were individually reviewed and alternative means were trialled (e.g. with replacement low beds and sensor mats, and increased use of concave mattresses). To date there have been no incidents involving these residents. All staff have attended relevant education and report they feel positive about using alternatives and can see the benefits of not using restraint. As a result of this initiative and further evaluation restraint use has decreased from 16 residents to 12 residents. A further review is planned in June 2021.</p>

required; and (h) Whether there are additional education or training needs or changes required to existing education.			
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End of the report.