Admatha Dementia Care Limited - Admatha Dementia Care, Admatha Lodge

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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Admatha Dementia Care Limited
Premises audited:	Admatha Dementia Care||Admatha Lodge
Services audited:	Hospital services - Psychogeriatric services; Dementia care
Dates of audit:	Start date: 19 May 2021 End date: 20 May 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 54

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Admatha Dementia Care provides psychogeriatric and dementia level care for up to 55 residents. The service is two buildings a secure psychogeriatric unit of 25 beds and a secure dementia unit of 30 beds. Each building is divided into two smaller homes. Occupancy on the days of audit was 54 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, management, staff and the general practitioner.

An operations manager and clinical manager manage the service. The operations manager has been in the role for five years. The clinical manager is an experienced registered nurse and has been in the role for one month and has been with the service over five years. Staff interviewed, and documentation reviewed identified that the service continues to provide dementia care and psychogeriatric services that are appropriate to meet the needs and interests of the resident group. Family interviewed all spoke positively about the care and support provided.

This audit identified that an improvement is required around completion of staff orientation.

The service is commended for achieving a continuous improvement in the area of restraint minimisation.

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.

Admatha Dementia Care provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

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.

Admatha Dementia Care implements the Dementia Care NZ (DCNZ) quality and risk management system that supports the provision of clinical care. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys. Incidents and accidents are appropriately documented and managed. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an on-line education programme covering relevant

aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

A well-presented information booklet for residents/families at entry includes information on the service philosophy, services provided (including family support groups) and practices particular to the secure units. Assessment and care plans are developed by registered nurses and reviewed six-monthly by the multidisciplinary team. Families are involved in the development and review of the care plan. A 24-hour multidisciplinary care plan identifies a resident's behaviours and activities or diversions that are successful. There is at least a three-monthly resident review by the medical practitioner. There is regular input form the psychogeriatric team.

The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident. Individual activity plans are developed in consultation with resident/family. There are community visitors involved in the programme, entertainers and van outings/scenic drives.

The medication management system meets legislative requirements. Registered nurses and medication competent caregivers are responsible for the administration of medications. Education and medication competencies are completed annually. The GP reviews the resident's medication at least three-monthly.

Meals are prepared in the main kitchen located in the lodge and transported to the home. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. There are nutritious snacks available 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

There is a current building warrant of fitness for each building. There is a reactive and planned maintenance schedule in place. The facility is divided into two separate buildings with two homes in each unit. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can personalise their rooms. There are lounge and dining areas, and small seating areas throughout the facilities. There is a designated laundry, which includes storage of cleaning and laundry chemicals. Chemicals and cleaning trolleys are stored securely when not in use. The service has implemented policies and procedures for civil defence and other emergencies. There is a trained first aider on duty 24 hours. All areas are appropriately heated and ventilated and have adequate external light. Safe external garden areas are available with suitable pathways with seating and shade provided.

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.

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. The service had no residents using enablers and four residents using restraints. The restraint coordinator/registered nurse (RN) maintains a register. Residents using restraints are reviewed a minimum of six-monthly by the approval group. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (a registered nurse) is responsible for coordinating/providing education and training for staff. The quality team supports the infection control coordinator. Infection control training has been provided within the last year with additional sessions relating to Covid-19. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other dementia care NZ (DCNZ) facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	48	0	1	0	0	0
Criteria	1	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Admatha Dementia Care has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Six caregivers (three from each unit across morning and afternoon shift), two diversional therapists, one cook and two registered nurses (RN) were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices, and this includes voluntary participation in daily activities as confirmed on interview with five relatives (two from dementia and three from psychogeriatric).
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display (Facebook) and consent for outings. Permissions granted are also included the admission agreements. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. Copies of the residents' advance directive where applicable, are on file. Seven of eight long-term resident files reviewed (three dementia and four psychogeriatric) had copies of the activated EPOA on file. The EPOA for one dementia level of care resident was being processed through the court.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main entrance of each home. Advocacy is regularly discussed at resident/relatives' meetings (minutes sighted). The service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the resident's family and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interview with relatives confirmed that visiting can occur at any time and families are encouraged to be involved with the service and care. Residents are supported to maintain former activities and interests in the community if appropriate.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The clinical manager with assistance of the national clinical manager leads the investigation of clinical related concerns/complaints. Complaints forms are visible and available for relatives. A complaints procedure is provided within the welcome pack at entry. The operational manager documents verbal complaints and these are managed as written complaints. There were six complaints recorded since March 2019 to end of 2020 (one HDC) and none recorded for 2021 to date. The complaints register is up to date and complaints sampled have been responded to and managed appropriately with letters of acknowledgement, investigations, staff meetings and letters of response, and outcomes to complainants. Management operates an 'open door' policy. The Ministry of Health requested follow up against aspects of two HDC complaints (one in 2018 and one in 2019) that included a comment on progress made on corrective actions associated with each one. The Ministry requested follow up against aspects of two HDC complaints (one in 2018 and one in 2019) that included (i) service provision requirements: Food and fluid management. Food and fluids chart. Monitoring and assessment. Monitoring for symptoms of dehydration, and electrolyte imbalances. (ii) Service Delivery/Interventions - Care planning. New tools developed to guide RNs in completing care plans. (iii) Internal audit tools. (iv) Medicine management. (v) Staff education including around content of clinical documentation and (vi) Assessment (implementation of the falls assessment tool). There were no identified issues in respect of these two complaints. The service has implemented the necessary corrective actions to improve service provision requirements,

		medication management, service delivery/interventions, assessments and staff education.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability (HDC) Commission. Relatives are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement. Family members interviewed confirmed they received all the relevant information during admission.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms. Family interviewed confirmed staff respect their privacy, and support residents in making choice where able. Staff have completed education around privacy, dignity and elder protection. Resident files are stored securely. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings were documented in the resident files sampled.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	The family are invited to be involved in care planning and any beliefs or values are discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six-monthly reviews occur to assess if the resident's needs are being met. Discussion with family members confirmed values and beliefs are considered.

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the eight staff files sampled. Staff comply with confidentiality and the code of conduct. The registered nurses and allied health professionals' practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the operations managers, the clinical manager, two registered nurses (RN) and six care staff confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Admatha Dementia Care policies and procedures meet the health and disability safety sector standards. Staff stated they are made aware of new/reviewed policies and sign to say they have read them. An environment of open discussion is promoted. Staff reported that the operations manager and clinical manager are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The registered nurses have access to external training. Discussions with family were positive about the care their relatives receive. A quality monitoring programme is implemented and monitors contractual and standards compliance and the quality-of-service delivery. The service monitors its performance through resident/relatives' meetings, quality meetings, infection control meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management. Five family members interviewed spoke very positively about the care provided and were well informed and supported. There are implemented competencies for all staff including caregivers and registered nurses.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	There is a policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The managers and registered nurses confirmed family are kept informed. Relatives stated they are notified promptly of any incidents/accidents. Families receive newsletters that keep them informed on facility matters and events. Incident and accident forms sampled, and files reviewed evidenced that family are notified following adverse events or when there is a change in resident's condition. Resident/family meetings encourage open discussion around the services provided (meeting minutes sighted). There is access to an interpreter service as required.

communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Admatha Dementia Care provides care for up to 55 residents requiring psychogeriatric care and dementia level care. There are two units in separate buildings. Admatha Lodge provides care for up to 25 residents requiring psychogeriatric care with full occupancy on the day of audit, including three younger residents on a 'Like in Age Interest' aged residential hospital specialised services (ARHSS) contract. Admatha Home provides care for up to 30 residents requiring dementia level care. There were 29 residents on the day of audit under the age-related residential care contract. Dementia Care NZ has a corporate structure in place, which includes two directors and a governance team of managers and coordinators. The operations management leader and national clinical manager support the operations manager and the clinical manager, respectively. The vision and values of the organisation underpin the philosophy of the service. The philosophy and the strategic plan reflect a person/family centred approach to all services. There is a strategic plan for 2020-2021 and a business plan for 2020-2021 in place for all DCNZ facilities. The 2020 organisational goals have been reviewed by the governance team, clinical advisor, quality systems manager and company educator/mental health RN. An operations manager and a clinical manager oversee daily operations of Admatha Dementia Care. The operations manager reports directly to the operations management leader and the clinical manager reports directly to the national clinical manager who reports to the managing director. The operations manager has been in the role for five years. The clinical manager is responsible for the clinical oversight of the service and has been in the position for one month and has worked at DCNZ for over five years. A newly created role of clinical support and quality team leader supports the clinical manager and national clinical manager. An organisational operations management leader, national clinical manager, quality systems manager, company clinical advisor, company educator/mental health RN and directors provide support to the team at Admatha Dementia Care. At the time of the audit the company director, national clinical manager, educator/mental health RN, clinical support and quality team leader and quality systems manager were present. The operations manager has attended at least eight hours of education in the past 12 months in relation to the role. The clinical manager is new to the role and is supported by the clinical support and quality team leader during her orientation period. The organisation holds an annual training days for all DCNZ operations managers and l clinical managers.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in	FA	During a temporary absence of the operations manager, the clinical manager assumes the role with support from the DCNZ management team.

an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation-wide quality and risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management plan is monitored through the quality meeting. The operations manager and clinical manager log and monitor all quality data. Meeting minutes are maintained, and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Quality improvement (QI) reports are provided at the monthly quality meeting. Staff interviewed confirmed involvement and feedback around the quality management system. Data is collected on complaints, accidents, incidents, infection control and restraint use. Benchmarking with other DCNZ facilities occurs on data collected. The service has policies and procedures to support service delivery. Document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The internal audit schedule has been completed for 2020 and being implemented for 2021 to date. Areas of non-compliance identified at audits have had corrective action plans developed and signed as completed. Internal audits include three monthly clinical documentation as part of quality improvement following an HDC complaint (link 1.3.13). The service has an implemented health and safety management system. There are risk management, and health and safety policies and procedures in place including accident and hazard management. The health and safety programme includes a specific and measurable health and safety goal that is specific to the site. Health and safety goals are established and regularly reviewed. A health and safety representative (caregiver) was interviewed and confirmed the health and safety committee meet monthly as part of the quality meeting. There is a current hazard register in place and reviewed three-monthly. New staff and contractors undergo a health and safety orientation programme. There is annual health and safety training and updates as part of the education planner. Staff interviewed confirmed health and safety matters are communicated to them through meeting minutes, a communication book, handovers or memo`s displayed on the staff noticeboards. The organisation's annual EPOA satisfaction survey was completed in 2020 and 2021. The results were communicated to relatives and staff through meeting minutes. Overall results reported that relatives are satisfied with the service and satisfaction improved by 15% from 2020 to 2021. The operational manager confirmed improvements were made to the information provided in the new welcome packs which have been well received by relatives. Falls prevention strategies are in place that includes critical thinking, clinical judgement and the involvement of

		the family/whānau as essential approaches to effective risk assessment and care planning. Best practice risk assessment tools, medication review, staff education, assessments with physiotherapy input and exercises/physical activities are part of the multifactorial interventions approach to minimise falls. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting 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.	FA	There is an accidents and incidents reporting policy. An online incident/accident register is maintained. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality improvement and clinical meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents and progress notes evidence good clinical judgement. Sixteen incident forms reviewed demonstrated that all appropriate clinical follow-up and investigation had occurred following incidents. Neurological observations were completed for six resident fall incidents reviewed with a suspected injury to the head or unwitnessed falls. Discussions with the operations manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications and were able to provide examples. There have been nine section 31 notifications completed since the last audit. Five were completed for unexplained absence from Admatha (missing resident) in January, September, October 2019 and June 2020 (x2), one for a physical altercation resulted in a fracture (April 2019) and one for a stage three PI. A respiratory outbreak was also notified to the public health authorities in August 2020. A notification to HealthCERT was completed for the change in clinical manager. Corrective actions have been developed, implemented and signed off for two residents related to five missing person notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	There are human resources policies to support recruitment practices. Eight staff files sampled (the operational manager, the clinical manager, two registered nurse, two caregivers, one cook, and one diversional therapist) contained all relevant employment documentation. Current practising certificates were sighted for the registered nurses (RN) and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Five of eight staff files evidenced a completed orientation and self-directed learning package. Staff interviewed confirmed new staff were adequately orientated to the service on employment. An education planner is in place and covers compulsory education requirements. Five of six RNs have completed interRAI training, one is yet to be enrolled. Clinical staff complete competencies relevant to their role and include (but not limited to), syringe driver, safe manual handling and transfer, medication administration, medication second checker competency and restraint minimisation competency. The service recently developed a documentation/care planning guide for RNs to assist with monitoring/assessment and

		care planning (link 1.1.13). There are 33 caregivers, five homecare assistants and two diversional therapists (DT) employed across the dementia unit and psychogeriatric units. Twenty-nine caregivers and the two DTs have completed the required dementia training as set out in E4.5 f ARRC and D17.11 c (i) ARHSS. Two newly appointed caregivers are yet to be enrolled and two caregivers are working towards the completion of the qualification and have been employed for less than 18 months. Care staff have access to enrolment and completion of Careerforce qualifications. Four caregivers are enrolled for the Careerforce DT qualification, and four caregivers are currently enrolled to complete different levels of the qualifications.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The operations manager and the clinical manager are on site full time and available after hours. There is a registered nurse on duty Monday to Friday for 40 hours per week in the dementia home and a registered nurse on duty 24/7 in the psychogeriatric unit. The caregivers and family interviewed informed there are always sufficient staff on duty. At Admatha Lodge (psychogeriatric) there are 25 residents in total, 13 of 13 residents in the Amour wing and 12 of 12 residents in the Mon-Ami wing. There is one RN on the morning and afternoon shift, and on the night shift. In the Amour wing the RN is supported by two caregivers (7 am-3 pm and 7 am-12.30 pm) one of which is home manager on the morning shift, two caregivers (3 pm-midnight and 3 pm-10 pm) on the afternoon shift and one homecare assistant on the morning shift (7 am-1 pm), one on afternoon (5 pm-9 pm) and night shift (midnight-7 am). The caregivers are supported by one diversional therapist (9 am-4 pm). In the Mon-Ami wing there are two caregivers (7 am-3 pm) one of which is home manager on the morning shift, two caregivers (3 pm-11 pm and 5 pm-10 pm) on the afternoon shift and one on the night shift (midnight-8 am). The caregivers are supported by one diversional therapist (1.30 pm-4.30 pm). At Admatha Home (dementia rest home unit) there are 29 residents in total, 16 of 17 residents in the Tai wing and 13 of 13 residents in the Awa wing. There is one RN on the morning shift (including the clinical manager). The RN is supported by two caregivers (one a home manager) on the morning shift (7 am-3 pm and 7 am-12.30 pm), three caregivers in the afternoon (3 pm-midnight; 4.30 pm-10 pm and 5 pm-9 pm), one diversional therapist (1.30 pm-4.30 pm) on the afternoon shift and one caregiver on the night shift (midnight-8 am) in the Tai wing. In Awa wing there is one caregiver and one homecare assistant on the morning shift (7 am-3 pm and 8 am-1 pm), one caregiver (3 pm-midnight), one homecare assistant (5 pm-7.30 pm) and one diversional therapist

		(1.30 pm-4.30 pm) on the afternoon shifts and one caregiver on the night shift (midnight-8 am).
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information is confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Files are integrated.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are pre-entry and admission procedures in place. All long-term resident files evidenced approval for the level of care by the psychogeriatric team and needs assessment coordinators. The clinical manager liaises closely with the assessing teams to ensure the service can meet the assessed resident needs. The service has a well-presented information booklet for families at entry. Information includes family support programmes and contact details for advocacy to how they can support and assist relatives with their family member with advanced dementia. Five family members interviewed (two dementia and three psychogeriatric) stated they received sufficient information on the services provided and were appreciative of the staff support during the admission process. Admission agreements reviewed in all files align with the ARC and ARHSS contract. Admission agreements had been signed within a timely manner.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a discharge planning and transfer policy to guide staff in this process. Discussions with two RNs confirmed that resident transfer/exit from the service is coordinated and planned and relevant people are informed. There is sufficient information to assure the continuity of resident's care through the completed internal transfer form, copy of relevant progress notes, resus status, copy of medication chart and doctor's notes. A yellow envelope transfer system is used for the DHB. A family member (as appropriate) accompanies the resident to the hospital.
Standard 1.3.12: Medicine Management Consumers receive	FA	The medication management policies and procedures comply with medication legislation and guidelines. All medications and medication trolleys are stored safely in the locked nurses' station in the Home (dementia care) and the Lodge (psychogeriatric care). All staff (RNs and senior caregivers) that administer medicines

medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		have completed annual self-learning packages and medication competency. Registered nurses only administer medications in the psychogeriatric units and 'as required' medications for the dementia care unit. Caregivers who have completed medication competencies administer medications in the dementia home. Medication robotic rolls are delivered fortnightly and checked in by an RN against the medication chart on the electronic medication system. All medication is prescribed for the person in the dementia care unit and psychogeriatric units, however there is a ward stock that can be used for hospital level residents. There are monthly checks of stock levels and expiry dates. Standing orders are used for hospital levels, meet the required format and are reviewed by the GPs annually. All eye drops sighted in the trolleys were dated on opening. The medication fridge temperatures and medication room/cupboards are monitored and recorded daily and within the acceptable range. There were no residents self-medicating. Sixteen medication charts (eight psychogeriatric and eight dementia) were viewed on the electronic medication system. All prescribing, and administration met legislative requirements. The GP reviews the medication charts three monthly. The psychogeriatric service reviews the use of antipsychotic medications on GP request. All charts had photograph identification.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The main kitchen is located in the Lodge adjacent to the dining room and has keypad entry. There are cooks on duty from 6.45 am to 5.15 pm daily. Cooks have completed food safety training and chemical safety training. The four-week menu is reviewed by a dietitian and resident preferences considered. All meals are prepared and cooked in the main kitchen. The meals (in containers) are transported to the dementia unit in hot boxes. The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Resident dislikes and allergies are known, and alternative foods are offered. Plates are name labelled where special dietary requirements are known. Special diets accommodated are gluten free, dairy free, soft and pureed. There are nutritious snacks available 24 hours in all kitchenettes. The homecare assistants in each unit assist with the serving of meals from each kitchenette, dishes and cleaning schedule for the kitchen. There is a current food control plan which expires 16 April 2022. There is daily monitoring of end-cooked food temperatures, fridge and freezer temperatures and inward goods. The chemical provider completes a monthly check on the dishwasher function and temperatures. A cleaning schedule is maintained. The dry goods store has all goods sealed and labelled. The cook was observed wearing appropriate personal protective clothing. Feedback is received from meetings, family members and through annual surveys. Food satisfaction has risen from 80% in 2020 to 93% in 2021.
Standard 1.3.2: Declining Referral/Entry To Services	FA	The reason for declining service entry to residents is recorded, should this occur and communicated to the resident/family (as appropriate). The clinical manager reports that the referring agency would be advised

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.		when a resident is declined access to the service.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The information gathered at admission such as allied health notes, needs assessment, discharge summaries and discussion with the EPOA is used to develop care needs and support to provide best care for the residents. An initial assessment covers all activities of daily living and specific assessment tools are used for behaviour, falls risk, nutritional risk and the pain assessment tool for advanced dementia. The physiotherapist completes an initial mobility assessment for all residents on admission and reviews residents post falls and at least six-monthly. The falls risk assessment tool is repeated for any resident with three falls or more in a month (link 1.1.13). First interRAI assessments had been completed for all residents and reviewed at least six-monthly as part of the routine long-term care plan evaluation. The outcomes of interRAI assessments including the risk assessments, were reflected in the long-term care plans reviewed. The diversional therapists and other activities staff complete a comprehensive social assessment in consultation with the resident/family. Four psychogeriatric resident files reviewed had an individual assessment that included identifying diversional, motivation and recreational requirements. Behaviour assessments had been completed for the dementia and psychogeriatric residents on admission and reviewed six monthly or earlier as required.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), EPOA, family and care staff. The long-term care plan is developed within three weeks of admission. The care plans reviewed were comprehensive and documented interventions to meet the resident needs including daily activities, mobility and falls prevention, pain management, behaviour management, food and fluid/nutritional status and medical needs (including the monitoring of electrolyte imbalances (link 1.1.13) and restraint (where required). The outcomes of interRAI assessments form the basis of the long-term care plan. Short-term care plans are used for short-term needs, reviewed and either resolved or transferred to the long-term care plan if an ongoing problem. Care plans demonstrate allied health input into the resident's care and well-being including the physiotherapist, dietitian, mental health services and podiatrist. InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process. Family members interviewed confirmed they are involved in the care planning process. Long-term

		care plans are signed by the relative or emailed/posted where the relative is unable to attend the care plan meeting. All dementia care and psychogeriatric level of care resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the RN initiates a GP or nurse specialist consultation. Short-term care plans are completed for changes to care/supports required and communicated at handovers. Registered nurses (RNs) and caregivers follow the care plan and report in progress notes against the care plan each shift. There is specialist input into the resident's care in the psychogeriatric unit as required. The community mental health/psychiatric nurses maintain a close liaison with the clinical manager/RN, GP and the psychogeriatrician based at the DHB. There is evidence in the medical notes of GP communication with the psychogeriatrician in regard to medication review. The relatives interviewed stated their expectations were being met and they were notified of any changes to health, incidents, infections, GP visits and medication changes. Staff have access to sufficient medical and clinical supplies available such as equipment and dressings. All wounds have wound assessments, pain scores, photos, sizes, dressing plan and evaluations completed on the due dates. There were two wounds in the psychogeriatric unit (one skin tear and one necrotic toe due to vascular impairment). There has been wound specialist input for the necrotic wound. There were no residents with wounds in the dementia care unit. One resident returned from hospital during the audit with three pressure injuries (three stage 2). Wound assessments were completed for each of the pressure injuries and a section 31 completed for the stage 3 pressure injury. Pressure relieving devices in place included roho cushion, pressure relieving mattress, heel protectors and two hourly repositioning charts. Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Behaviours that challenge have been well identified through the assessment process in the residents' files reviewed. Twenty-four-hour multidisciplinary care plans describe the resident's usual signs of wellness, changes and triggers, interventions and de-escalation techniques (including activities), for the management of challenging behaviours. Behaviour charts and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours. Daily forms are completed for the monitoring of whereabouts of residents at risk that evidence 15 minutes physical checks. The form also includes the clothing the resident is wearing on the day. Monitoring forms include pain, observations, neurological observations, 24-hour fluid intake, blood sugar levels, weight, re-positioning charts, food and fluid, resident hygiene and bowel charts, restraint monitoring and toileting charts.

Standard 1.3.7: Planned Activities 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.	FA	There is a team of six activities coordinators who provide an activity programme in each of the homes (dementia level and two psychogeriatric level). There are two diversional therapists (DT) and four in DT training. There is one activity staff member in each of the four “homes” seven days a week. In the dementia unit there is an activity person on from 1.30 pm-4.30 pm each day. In the psychogeriatric “homes” there is an activity person who starts at 9 am-4 pm and rotates between the two homes in the mornings. Another activity person commences at 1 pm-4.30 pm. In the mornings, caregivers are involved in household and meaningful activities with residents. There is a separate afternoon programme for each unit which is flexible to meet the resident cognitive and physical needs. The programme for the psychogeriatric and dementia residents is focused on individual and small group activities that are meaningful, including household tasks (folding washing, raking leaves, watering garden), reminiscing, sensory activities, cooking club/baking, garden walks, gardening, flower arranging, arts and crafts, board games, floor games, movies, feeding the ducks, colouring/painting, reading and happy hours. There is one-on-one pampering sessions for the ladies and men. The hairdresser visits regularly. There is a monthly combined men’s club. Informal activities occur throughout the 24-hour period as required with caregivers also involved in one-on-one activities. There are resources available to staff for activities. The therapy dog (Merlin) visits weekly. Entertainers visit in the weekends and there are volunteers who do church services and hymns. Van outings/scenic drives are weekly and there are two activity staff on each outing. The facility has a wheelchair van. All activity staff have a current first aid certificate. A comprehensive my profile and social history is completed soon after admission and information gathered from the relative (and resident, as able) is included in the activity care plan. A 24-hour MDT care plan is reviewed at least six-monthly. The programme observed was appropriate for older people with mental health conditions and dementia. Activities were observed to be occurring in the lounges during the audit. Feedback on the programme is received through monthly resident meetings in each unit and relative gathering. Relatives interviewed confirmed their satisfaction around activities offered. There were bright photo display boards in each unit of resident involvement in activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Files reviewed (for all long-term residents) demonstrated that the long-term care plans were evaluated at least six-monthly (or earlier if there was a change in health status). Changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing, as sighted in resident files reviewed. Six-monthly MDT meetings were held with the EPOA/relatives and meeting minutes records where progress is different from expected. Changes are updated on the long-term care plan. The GP reviewed the resident at least three-monthly. Other allied health professionals involved in the care of the resident provide input at the six-monthly evaluation such as the physiotherapist and mental health services.

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 provided to meet consumer choice/needs.	FA	The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Family/EPOA are involved as appropriate when referral to another service occurs. The service liaises closely with the need's assessment and psychogeriatric team. At the time of audit there was one example where a resident's condition had changed and required reassessment from dementia level of care to psychogeriatric level of care.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies and procedures in place for waste management. Residents, staff and visitors are protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are stored safely throughout both buildings. Chemicals are labelled with manufacturer labels. Safety data sheets are available. There is a sluice area in both units. Product use information is available. Protective equipment including gloves, aprons, and goggles are available and were observed to be worn by staff when carrying out their duties on the days of audit.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The Admatha dementia care building has a building warrant of fitness that expires 1 April 2022. The Admatha Lodge (psychogeriatric level of care) has a building warrant of fitness that expires 1 June 2021. There is a maintenance request log in each RN nurses' station. The operations manager oversees minor maintenance requests. Essential contractors are available 24 hours. There is a planned maintenance programme in place. A maintenance person is contracted for the Christchurch facilities and completes the planned maintenance schedule (sighted) which has been completed to date. Contractors' complete calibrations and functional checks for clinical and medical equipment. The maintenance contractor has an electrical test and tag certificate and has completed electrical checks. There are painters employed by DCNZ who rotate around all facilities to refurbish rooms as they become vacant and carry out other refurbishments as required. Weekly hot water temperatures are monitored and randomly checked from each of the three hot water systems. There has been a recent upgrade replacing hot water cylinders due to low hot water temperatures. The internal areas of both the units are spacious and facilitate ease of movement for residents using mobility

		aids or for the use of hospital level of care equipment if needed. There are seating alcoves for rest periods. Both homes have safe outdoor gardens and grounds with walking pathways, raised gardens, seating and shade. A gardener is employed to maintain the gardens and grounds. A children's playground has been developed in the dementia care unit grounds. Staff stated residents enjoy seeing children play while visiting. Care staff and RNs interviewed confirmed they have sufficient equipment to carry out the cares documented in the care plans.
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	A mixture of full ensuite, shared ensuite and communal facilities are provided at Admatha Home. There are communal toilet/shower facilities at Admatha Lodge. There are sufficient communal toilets adjacent to the lounge and dining areas in both units. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use signs. There is a large shower/bathroom in the Lodge that can accommodate a tilting shower chair or shower trolley if required.
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	The rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place. Bedrooms are personalised.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age	FA	Each building has two "homes" each with an open plan dining/lounge area and kitchenette. There are seating alcoves and smaller sitting areas for residents and families to access. Communal areas in each unit are used for activities, recreation and dining activities. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents have free access to the outdoor areas from several exit/entry points.

appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry (including sluice area) located in the Lodge. There is a defined clean/dirty area. All linen and personal clothing is laundered on site. The laundry is completed by a designated homecare assistant from midnight to 7 am seven days a week. There is a locked cleaners' room within the laundry where the cleaning trolley is stored when not in use. There is an oasis chemical mixing system. The chemical provider monitors the use of chemicals and the laundry processes. Staff attend safe chemical handling and infection prevention and control education and there is appropriate protective clothing available. Homecare assistants carry out the cleaning duties and were seen to be wearing appropriate personal protective clothing while carrying out their duties. Safety charts were available for reference if needed in an emergency. Family interviewed reported satisfaction with the laundry service and cleanliness of the facility.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The service has a fire and emergency procedures manual. There is an approved New Zealand Fire Service evacuation scheme for the Home and Lodge. The evacuation scheme for the Lodge was approved in June 2003. Six monthly fire drills are conducted and the last occurred in April 2021. There is a trained person with a first aid certificate on each shift. Fire safety, civil defence and emergency preparedness training has been provided. There is a call bell system in place in both facilities. A civil defence kit is stocked and checked monthly. Water is stored, sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. The facility has gas cooking and hot water. There are emergency management plans in place to ensure health, civil defence and other emergencies are included.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and	FA	All communal areas and resident bedrooms have external windows with plenty of natural sunlight. A mix of underfloor electric heating, wall panels and heat pumps (all of which are electric) heat the facility. Windows open for ventilation. The general living areas and resident rooms were appropriately heated and ventilated.

comfortable temperature.		
Standard 3.1: Infection control management 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.	FA	The Infection Control (IC) programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse has been in the role five months (and as a RN for over two years) and has a job description outlining the responsibilities of the role. She is supported by an infection control committee and the national clinical manager at head office. The infection control programme is reviewed monthly at the committee meetings and annually at an organisational level. There are six-monthly clinical manager/infection control nurse meetings for all facilities. Visitors are asked not to visit if unwell. There is QR screening and declarations in place for all visitors and contractors that visit the facility. Hand hygiene notices are in use around the facility and there are hand sanitisers strategically placed throughout both buildings. Relatives have been kept updated on visiting policies during Covid-19 lockdown and outbreak lockdown by phone calls, emails and facebook notices. Admatha is a pilot facility for Covid-19 vaccinations for residents and staff. Residents had been vaccinated the week of audit and staff had receive their vaccination in small groups. Each resident had a short-term care plan to guide staff in reporting any adverse effects.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The monthly infection control committee meeting includes representatives from across the services. The committee meet monthly, and data is discussed and published in the monthly quality bulletin that is available to all staff. The infection control nurse has completed Covid-19 online learning March 2020 and online infection prevention and control health learning March 2021. The service also has access to an infection control and prevention team at the DHB, Public Health, GPs and local community laboratory infection-control team.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are	FA	There is an infection control manual, which includes policies and procedures appropriate for the size and complexity of the service. Policies are reviewed at head office in consultation with all DCNZ infection control nurses. Any changes or updates to the infection control policies are notified at staff meetings and are recorded in the staff bulletin. There is a DCNZ Covid-19 policy and outbreak management plan in place.

readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control nurse is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control hand-hygiene competency and self-learning package annually. There has been additional Covid-19 training including weekly meetings, the correct use of personal protective equipment and donning and doffing competencies. There is an infection control focus every month which includes in-service.
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	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control nurse collates monthly data for all infections based on signs and symptoms of infection. Surveillance of all infections for the dementia and psychogeriatric units is entered separately into a monthly infection summary. Surveillance results are reported to the infection control committee and facility meetings and minutes are made available to read. Trending and analysis of infections monthly and annually is reported in the monthly quality bulletin. The data has been monitored, evaluated and benchmarked at organisational level. Care staff interviewed were aware of infection rates. Systems in place are appropriate to the size and complexity of the facility. There has been one upper respiratory tract infection in August 2020 contained to one of the “homes” in the dementia care unit. Negative Covid-19 swabs confirmed an upper respiratory virus. Public Health notification and a section 31 notification was sighted.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.2. The policy includes comprehensive restraint procedures. Interviews with caregivers and nursing staff confirmed their understanding of restraints and enablers. There were no residents using enablers on the day of audit. A register is maintained by the restraint coordinator/RN (clinical manager). On the day of the audit there were four residents with restraints in Admatha Lodge (three H-belts and one bedrails) and there were no residents with restraints or enablers in Admatha home. An assessment for restraint use and consent form were evidenced in the two resident files with restraints reviewed. Staff regularly receive education and training on restraint minimisation (last occurring in January 2021) and management of actual and potential

		aggression (MAPA) last occurring May 2021.
Standard 2.2.1: Restraint approval and processes 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.	FA	Responsibilities and accountabilities for restraint are outlined in the restraint policy and include roles and responsibilities for the restraint coordinator (RN) and approval group. A restraint approval group meets six-monthly, and the restraint objectives are reviewed at the same time. The group includes the restraint coordinator, clinical manager, operations manager, DT and company educator. All staff are invited to the review meetings.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments are undertaken by the restraint coordinator/RN in partnership with the resident and their family. Restraint assessments are based on information in the care plan, family, staff and GP consultation and during observations. The restraint assessment tool is completed for residents requiring an approved restraint for safety. There is provision for emergency restraint if required for safety of the residents, other residents/staff. Ongoing consultation with the family and staff is evident through multidisciplinary meetings and facility meetings. There were four psychogeriatric level residents with the use of restraint as required (three H restraints and one bedrail). Two restraint files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation is included in the restraint policy. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the family, restraint coordinator and GP. Internal audits are completed three-monthly, ensuring all restraint processes are completed as per the restraint policy and procedures. The restraint coordinator reported that each episode of restraint is monitored at predetermined intervals, depending on individual risk to that resident. Monitoring is documented on a specific

		restraint monitoring form (sighted). A restraint register is in place providing an auditable record of restraint use. This has been completed for all residents requiring restraints.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur monthly in the registered nurses meeting and six-monthly as part of the multi-disciplinary review for the residents on restraint. Families/EPOA are included as part of this review. A review of two files of residents using restraints identified that evaluations were up to date.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	CI	At the monthly facility quality meetings, RN meetings, staff meetings and six-monthly restraint meetings, restraints are discussed and reviewed. Any incidents of emergency physical restraint (which are infrequent and documented and investigated through the incident reporting system) are also reviewed at these meetings. Meeting minutes include a review of the restraint and challenging behaviour education and training programme for staff. Staff receive orientation in restraint use on commencement of employment. The company education coordinator provides training for staff. There is internal benchmarking, and the service has exceeded the requirements for the attainment of this standard.

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)
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	The current orientation policy was reviewed and states that core orientation needs to be completed within six weeks of commencement of employment and personal grooming skills and competency within the workbook needs to sign off for caregivers within a ‘few days’ of orientation. Eight staff files were reviewed, and the company educator and operational manager were interviewed. Four of the eight files evidenced a completed orientation/self-directed learning workbook and signed off in the stated timeframes. The new appointed clinical manager was in the process of completing her orientation to the role. One caregiver has not completed the safe manual handling and personal grooming skills assessment within the stated timeframe set out in the service policy; another caregiver evaluation of orientation section was incomplete. For one RN the emergency preparedness section related to civil defence was incomplete.	Four of eight staff files reviewed included inconsistencies in the sign off of the orientation workbook.	Establish processes which ensure that orientation/self-directed learning workbooks content is fully completed prior to sign off of the programme. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
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 required; and	CI	In January 2020, Admatha Dementia Care recognised the same residents were on H belts from the previous year and committed to detail analysis of those events in order to minimise restraint use. This quality improvement initiative aligns with the DCNZ Strategic plan. Admatha Dementia Care is committed to minimising restraint by recognising collaboration, support for staff and participation of family/whānau through effective communication. The overall approach has resulted in a sustained reduction of restraint hours per residents, a continuous focus on a person-centred approach to restraint use and empowerment of staff to implement alternative strategies to	Data was collected throughout the year of each resident, which measures the use of restraint in hours per month per resident. A resident event analysis report is part of several meetings and included in the clinical quality bulletin and operational bulletin and used as a quality improvement tool. The events analysis includes residents’ individual risks, associated behaviour and time of day the restraint is used. Overall communication has had the largest impact on the reduction of restraint. Care staff interviewed confirmed they are encouraged to

(h) Whether there are additional education or training needs or changes required to existing education.		restraint.	use the 'Best Friends approach to care' to de-escalate potential aggressive behaviour. Training and support are provided with the support of a 'behaviour and psychological symptoms and dementia' (BPSD) advisor. Registered nurses are supported through monthly support meetings/coaching sessions using the GROW model. The last staff survey evidenced 92% of staff feel supported and 'look forward' to coming to work. Family has the opportunity to provide feedback during restraint response surveys, monthly family support meetings and six monthly multi-disciplinary meetings. The recent family/whānau/EPOA survey evidenced an overall satisfaction of 95% with service delivery. Consistent completion of restraint documentation evidenced a culture of compliance. The service reported the H-belt per hour per resident has decreased. This was evident in the trend analysis and the consistent decrease of hours of H-belt restraint use per resident. There were no incidents recorded of the use of emergency restraint or harm caused by restraints for the period January 2020-April 2021.

End of the report.