

Thyme Care Limited - Ripponburn Home and Hospital

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:	Thyme Care Limited
Premises audited:	Ripponburn Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 December 2021 End date: 14 December 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:	35

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

Ripponburn Home and Hospital has been privately owned since January 2021. The service provides rest home and hospital (medical and geriatric) care for up to 46 residents. On the day of the audit there were 35 residents.

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

An experienced aged care management team oversee the service. The care manager (registered nurse) started in the role in March 2021 and has many years in aged care management. A clinical nurse manager with extensive facility experience supports the nurse manager. The management team are supported by a board of trustees.

Residents, relatives, and the GP interviewed spoke positively about the service provided.

This audit identified two shortfalls related to care planning and medication management.

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.

The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during their entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy, and informed consent.

Cultural values and beliefs are understood and respected. Care planning accommodates individual choices of residents and/or their family/whānau. Informed consent processes are adhered to. Residents are encouraged to maintain links with their community.

Complaints processes are implemented, and complaints and concerns are managed appropriately.

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.

Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are implemented. Strategic goals are documented for the service with oversight provided by a board of trustees. Incident and accident reporting, and health and safety processes are embedded in practice. Quality systems include regular monitoring of quality and risk data and an internal auditing programme.

Human resources are managed in accordance with good employment practice. An orientation programme and a regular staff education and training programme are in place. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--	--	--

An admission package is provided to family and residents prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses are responsible for all aspects of care planning, assessment, and evaluation of care with the resident and/or family input. Resident files included medical notes by the general practitioner and visiting allied health professionals.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing, and social interaction appropriate to the level of physical and cognitive abilities of the rest home and hospital care residents.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts were reviewed at least three-monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. There is dietitian review of the menu. Residents commented very positively on the meals provided.

Safe and appropriate environment

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

The building has a current building warrant of fitness certificate, and all external areas were accessible and of an appropriate standard. There is a preventative and planned maintenance schedule in place. Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated.

Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Fixtures, fittings, and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. A staff member trained in CPR and first aid is on duty at all times.

Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. At the time of the audit five hospital level residents were using a restraint and no residents were using an enabler.

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 prevention and control programme include policies, standards, and procedures to guide staff. 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 coordinator (RN) is responsible for coordinating/providing education and training for staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. A monthly infection control report is completed. There have been no outbreaks.

A pandemic plan was actioned, and Covid-19 policies and procedures have been developed and implemented. Ripponburn Home and Hospital continues to implement current Covid-19 regulations around contact tracing.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	0	2	0	0
Criteria	0	99	0	0	2	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	The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. The care manager [registered nurse (RN)], clinical manager/RN and nine staff interviewed (two registered nurses (RNs), three caregivers who work in both the rest home and hospital wings, one chef, one housekeeping supervisor, one diversional therapist, one maintenance) were able to describe how the Code is incorporated into their job role and responsibilities. Staff receive training on the Code during their induction to the service. This training continues via the staff education and training programme.
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	The service has policies and procedures relating to informed consent and advanced directives. All six resident files reviewed included signed informed consent forms and advance directive instructions. Staff are aware of advance directives. Admission agreements were sighted, which were signed by the resident or nominated representative. Discussion with residents identified that the service actively involves them in decision making.

<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>Health and Disability advocacy details are included in the information provided to new residents and their family during their entry to the service. Residents and family interviewed are aware of the role of advocacy services and their right to access support. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.</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>The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.</p> <p>Community links are being implemented with evidence provided of how the local community supports the facility. Residents attend outings as they are able (e.g. local church services, RSA, craft group). Residents who are able are supported to come and go from the facility as they please. One resident still drives his own car.</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 procedure is provided to residents and families during the resident's entry to the service. Complaints forms are located at the entrance to the facility. The complaints process is linked to advocacy services.</p> <p>An electronic record of complaints received is maintained by the care manager. Seven complaints have been lodged in 2021 (year-to-date). Complaints are being managed in accordance with HDC guidelines. Complaints lodged were documented as resolved. Trending of complaints indicates that multiple issues have arisen around food satisfaction with corrective actions implemented as per the quality programme.</p> <p>Discussions with residents and families confirmed that they are provided with information on the complaints process and remarked that any concerns or issues they have are addressed. The complaints process is linked to the quality and risk management system with staff kept informed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code and the HDC advocacy service are included in the resident information that is provided to new residents and their families. Aspects of the Code are discussed with residents and their family on admission. Discussions relating to the Code are also held during the residents' meetings.</p> <p>Interviews with seven residents (five hospital and two rest home) and five family (hospital) confirmed</p>

		that the residents' rights are being upheld by the service.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' personal belongings are used to decorate their rooms. The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas.</p> <p>Caregivers reported that they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected. All shared bathrooms and showers have privacy signage/locks in place.</p> <p>There are nine double rooms available. Curtains provide visual privacy. Call bells are located next to each bed. One of the four occupied double rooms is occupied by a married couple. For the remaining three shared rooms, written consent to share a room is obtained by the resident and/or family.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect, which begins during their induction to the service and continues as a regular in-service topic.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>A Māori health policy is documented for the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau to assist with the care of the residents. The facility has a relationship with a Queenstown-based kaumatua and plan to implement regular staff activities once they have designated a cultural champion team to do this.</p> <p>Education on cultural awareness begins during the new employee's induction to the service and continues as a regular training topic. There is one staff member who is not mana whenua but is confident in tikanga. The manager and clinical manager have been attending Māori te reo classes. A seminar planned around te Reo Māori, tikanga, and the Treaty of Waitangi has been postponed for 2021 and is rescheduled for 2022.</p> <p>Cultural considerations and interventions are identified in the resident's care plan. There were no Māori residents living at the facility at the time of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	FA	<p>The service identifies the residents' personal needs and desires from the time of admission. The staff demonstrated through interviews and observations that they are committed to ensuring each</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>resident remains a person, even in a state of decline.</p> <p>Beliefs and values are incorporated into the residents' care plans. Residents and family/whānau interviewed confirmed they were involved in developing the resident plan of care, which includes the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The care manager is a registered nurse with many years of senior management experience in an aged care environment. She is supported by an experienced full-time clinical manager. A general practitioner is onsite two days a week. Residents are reviewed by a general practitioner (GP) every three months at a minimum.</p> <p>Residents and family interviewed reported that they are generally satisfied or very satisfied with the services received. This was also confirmed in the 2021 resident/family satisfaction survey.</p> <p>The service receives support from the district health board (DHB). A physiotherapist is onsite two days a week. A podiatrist visits the facility every six weeks. A number of improvements have been implemented since the previous audit including (but not limited to): enhancements to the environment (e.g. outdoor garden seating area), the purchase of a new hoist, implementation of an electronic quality and patient management system (Leecare), the implementation of an online staff learning and development programme, and the implementation of a robotic medication system.</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>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The care staff interviewed understood about open disclosure and providing appropriate information when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Fifteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. Staff</p>

		and family are used in the first instance.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Ripponburn Home and Hospital provides care for up to 46 rest home and hospital (geriatric and medical) level care residents. On the day of audit, there were 35 residents; 12 rest home, including one resident on respite; and 23 hospital residents, including one resident on a long-term service – chronic health conditions (LTS-CHC) contract and one on ACC. All remaining residents were under the age-related residential contract (ARC). Four rooms in the rest home wing are designated as dual purpose (rest home or hospital).</p> <p>The service has a current strategic plan that identifies the purpose, values, and scope of the business. The service is governed by a trust board who regularly reviews strategic goals. Three board members were interviewed and confirmed strategic goals are regularly reviewed.</p> <p>The care manager is a registered nurse and has been employed by Ripponburn Home and Hospital since March 2021. She has over 30 plus years of aged care experience with 25 years of senior management experience. She is supported by a clinical manager/RN who has been in the role since January 2021. The clinical manager has seventeen years of aged care experience.</p> <p>The care manager and the clinical manager have completed over eight hours of professional development related to their respective roles.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager is responsible for facility operations in the absence of the care manager.</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</p>	FA	<p>Quality and risk management systems are established and implemented. Policies and procedures align with current good practice. Policies have been reviewed, modified (where appropriate) and implemented. New policies are discussed with staff as an agenda item, sighted in the monthly staff meeting minutes.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data is collected for a range of adverse event data (e.g. skin tears, falls (witnessed and unwitnessed), infections) with</p>

improvement principles.		<p>results posted in the staff room. An internal audit programme is being implemented. Corrective actions are developed and implemented for areas identified for improvements. Staff are informed of quality results, including corrective actions, via staff meetings. Meeting minutes are available electronically for staff to read.</p> <p>The health and safety team have completed stage one health and safety training. Staff health and safety training begins during their induction to the service. Health and safety is a regular topic covered in the two-monthly staff meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. New contractors undergo orientation to health and safety as per the facility's health and safety policy and procedures.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) sensor mats, regular toileting, and intentional rounding. A notice board in the staff room identifies those residents at risk of falling.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the service's quality and risk management programme.</p> <p>Fifteen accident/incident forms were reviewed (witnessed and unwitnessed falls, pressure injuries, skin tears, bruising, medication errors, challenging behaviours). Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurologic observations are conducted for suspected head injuries and unwitnessed falls.</p> <p>The care manager and clinical manager are aware of statutory responsibilities in regard to essential notification. Section 31 reports have been completed to address the appointment of the care manager and clinical manager. There have been no outbreaks since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements</p>	FA	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Seven staff files were randomly selected for review (five caregivers, one activities assistant, one RN). Files reflected evidence of the recruitment and induction process, including reference checking, signed employment contracts, job descriptions, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice that is specific to the position. Staff interviewed stated that new staff were</p>

of legislation.		<p>adequately orientated to the service.</p> <p>An education and training programme is provided for staff. Staff training is frequently linked to staff meetings. Competencies are completed specific to worker type and include (but are not limited to) medication/controlled drugs and the recently introduced electronic patient management system.</p> <p>Out of 44 caregivers, three caregivers hold a level three qualification and four hold a level four qualification.</p> <p>A register of current practising certificates for health professionals is maintained. Three of six RNs have completed their interRAI training. A first aid trained staff is available 24/7, including on outings.</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>The service has a documented rationale for determining staffing levels and skill mix for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The care manager and the clinical manager are on site full time (Monday – Friday) and available after hours. A minimum of one registered nurse is onsite 24 hours a day, seven days a week.</p> <p>There are two wings in the facility: a rest home level wing (Pisa wing) with four dual-purpose beds, and a hospital level wing (Kawarau wing). An RN is based in the hospital wing with oversight in the rest home wing.</p> <p>Caregiver staffing:</p> <p>Pisa wing (twelve rest home and four hospital level residents): AM - one long (eight-hour shift) and one short shift (1630 to 1230); PM – one long and one short shift caregiver (1630 – 1930); night – one caregiver.</p> <p>Kawarau wing (19 hospital residents): AM - three long and one short shift (to 1230); PM – two long and one short shift (1530 – 2000); night - one caregiver.</p> <p>Interviews with residents and families confirmed staffing overall was satisfactory although difficulties arise when staff call in and vacancies are unable to be filled. The roster indicates those staff who have worked a night shift so that they are not contacted the following day. At the time of the audit, one RN and one caregiver vacancy had been filled and were beginning work later in the week. There was one full-time caregiver vacancy in addition to vacancies for casual staff.</p>
Standard 1.2.9: Consumer Information Management Systems	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also</p>

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files demonstrate service integration. An electronic patient management system has recently been implemented with work underway to embed this system into practice. Entries are dated, timed, and signed by the relevant caregiver or RN, including designation.
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	<p>All residents are assessed prior to entry for rest home or hospital level of care. The service has specific information available for residents/families/whānau at entry and includes associated information such as the Code, advocacy, and the complaints procedure.</p> <p>Comprehensive information is available to all residents/family/whānau on enquiry or admission. The information includes examples of how services can be accessed that are not included in the agreement. Registered nurses interviewed were able to describe the entry and admission process. The GP is notified of a new admission.</p> <p>Six signed admission agreements were sighted. The admission agreement reviewed aligns with the ARC contract. Exclusions from the service are included in the admission agreement.</p>
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service. The yellow envelope system is used for transfers to hospital.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	<p>Medicine management policies and procedures that meet legislative requirements are in place and implemented. The RNs and senior caregivers who administer medications complete annual medication competencies and education on medication is provided. All medication is stored in a locked cupboard in the central nurses' station or in the treatment room. Fridge and air temperatures met requirements.</p> <p>An RN does a weekly check for expired medication. Unwanted or expired medications are collected by the pharmacy weekly. Medicines (blister packs) are delivered weekly by the pharmacy, checked by an RN on-site verified on the electronic medication system. Any discrepancies are fed back to the pharmacy. Policies and procedures for residents self-administering are in place and this includes ensuring residents are competent and safe storage of the medications.</p>

		<p>There was one hospital resident who self-administers specific medications on the day of the audit. The resident had competencies in place which had been signed and reviewed three-monthly by the GP. There are no standing orders or 'nurse initiated' medications used. Not all eye drops in use were noted to be dated at opening or discarded within required timeframes. A bulk supply of stock medicines was available in the hospital. Controlled drugs are stored securely however weekly checks have not been consistently documented.</p> <p>A medication round was observed; the procedure followed by the registered nurse was correct and safe. The service uses an electronic medication administration system.</p> <p>Twelve individual resident's medication charts were reviewed. Resident medication charts are identified with photographs. All charts had been correctly signed and all discontinued medications had been signed and dated. All PRN medications included indication for use and the effectiveness of as required medications was documented in the electronic medication system. There was evidence of three-monthly review by the GP. Allergies were recorded for all residents.</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>	FA	<p>The residents' individual food, fluids and nutritional needs were met. Residents are provided with a balanced diet which meets their cultural and nutritional requirements. All meals at the service are prepared and cooked on site. The cook works from 6am to 2:30 pm and is supported by a kitchenhand from 11:45am to 7:45 pm. Meals are prepared in a well-appointed kitchen in the Pisa wing adjacent to the main dining room and served from a Bain Marie. The Kawarau hospital meals are delivered in a portable Bain Marie and served to the residents. Staff were observed delivering meals and assisting residents with their lunchtime meals as required.</p> <p>The four-weekly seasonal menu was last reviewed by a registered dietitian in Sept 2019. A current review is in progress after a delay related to Covid restrictions. The current evidenced dietetic input into the provision of special menus and diets where required. A dietary assessment is completed on all residents at the time they are admitted. Residents with special dietary needs, allergies, cultural and religious preferences, likes, and dislikes have these needs identified. Resource information on these diets is available in the kitchen and via the dietitian. A dietary requirement list is generated from the electronic and includes new admissions and dietary changes. The list is posted on a noticeboard in the kitchen.</p> <p>A kitchen cleaning schedule was in place and implemented. Labels and dates on all containers and records of food temperature monitoring were maintained. The chiller, fridge and freezer temperatures were monitored. The kitchen was observed to be clean and well organised. All aspects of food procurement, production, preparation, storage, delivery, and disposal complied with current legislation and guidelines.</p>

		<p>Kitchen staff are trained in safe food handling, and food safety procedures were adhered to. The cook is a qualified chef with 26 years' experience at Ripponburn Home and Hospital. The food control plan expires in March 2022.</p> <p>Resident meetings and surveys provide an opportunity for resident feedback on the meals and food services. Interviews with residents and family members indicated satisfaction with the food service.</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>The reason for declining service entry to residents to the service is recorded. Should this occur, the service stated it would be communicated to the resident/family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.</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>Registered nurses complete an initial assessment and care plan on admission to the service which includes relevant risk assessment tools including (but not limited to); falls risk, detailed pain, pressure injury, skin, continence, and nutritional assessments. Risk assessments are completed six-monthly or earlier due to acute health changes. InterRAI assessments and long-term care plans were completed within the required timeframes, however, outcomes of assessments were not always reflected in the needs and supports documented in the care plans on the electronic system (link 1.3.5.2). Other available information such as discharge summaries and plans, allied health notes, and consultation with resident/relative or significant others are included in the electronic long-term care plans. Wound assessments were completed to assist with wound management. The outcomes of assessments form the basis of the long-term care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Six resident files sampled all included a care plan and input from allied health. There was evidence of service integration with documented input from a range of specialist care professionals, including, wound specialists, dieticians, physiotherapy, and podiatry support. The service uses electronic assessments which then update long term care plans for changes in health status. Short-term needs are added to the long-term care plan when appropriate and removed when resolved.</p> <p>Resident care plans reviewed were resident-centred however did not always document the required support needs in sufficient detail. Residents with challenging behaviours had these identified in the care plan however triggers and management strategies were not always documented in sufficient</p>

		<p>detail to guide care staff.</p> <p>Activities assessments and plans were in place for all resident files reviewed.</p> <p>The residents and relative interviewed confirmed they were happy with the delivery of care. Caregivers interviewed reported they found the care plans easy to follow and contain information to provide quality care for residents.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Residents received adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions were documented for each goal in the long-term care plans. Interventions from allied health providers were included in the long-term and short-term care plans.</p> <p>Dressing supplies and continence products are readily available. There are sufficient stocks of PPE to meet requirements. If external allied health requests or referrals are required, the clinical manager initiates the referral (e.g., wound care specialist, dietitian, or mental health team). A physiotherapist visits twice weekly and reviews new residents. Registered nurses interviewed were able to describe access to specialist services if required.</p> <p>Wound assessment and wound management plans were in place for eight residents with eight wounds: one stage two pressure injury, three skin tears, two lesions and two other. The pressure injury is slowly healing. All wounds have documented assessments and a treatment plan in place. All wounds show evidence of healing. The long-term care plans reflect acute wound care had interventions around management of wounds and dressings.</p> <p>The residents' files included a urinary continence assessment, bowel management plan, and continence products used. There were adequate supplies of incontinence products. The clinical nurse manager interviewed confirm continence advice can be obtained</p> <p>Changes in health such as weight loss, wound management or infections are assessed and reflected in the electronic long term care plans health. These had been reviewed</p> <p>There was evidence of monitoring including positioning charts, monthly (or more frequent) weight and vital sign monitoring, catheter changes, blood glucose levels food and fluid charts and behaviour charts in place.</p> <p>The relatives interviewed stated that the clinical care is good and that they are involved in the care planning. Interviews with registered nurses and caregivers demonstrated understanding of the individualised needs of residents.</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>	<p>FA</p>	<p>The activity programme confirmed that independence was encouraged, and choices were offered to residents. The experienced diversional therapist works 38 hours a week and is providing a varied and innovative programme. She is supported by three additional activities coordinators who work 9am to 3pm during the week and rotate to provide cover from 10am to 5pm on Saturday and 10am to 1pm on Sundays. The programme includes a range of activities which meets the abilities and needs of both hospital and rest home residents.</p> <p>Activities included physical, mental, spiritual, and social aspects of life to improve and maintain residents' wellbeing. Activities included bus trips, exercises, indoor sports, church services, pet therapy, community visits from the returned services association, church groups, schools, and preschools (depending on Covid -19 guidelines) and men's outings to a local tavern. Combined activities with other facilities in Otago include activities such as a pie day in Roxborough, picnics under the trees at Ripponburn, and pony and cart rides. One-on-one time is spent with residents with individual activities such as walks, reading and chats, gardening and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated.</p> <p>There are volunteers involved in the programme, including a group of ladies who run a knit and knot group, newspaper readers, and regular church groups. Pet therapy is provided according to Covid-19 guidelines, and gardening in a well-established raised garden is available for residents.</p> <p>On admission, the diversional therapist completes a profile for each resident within three days and an activity plan is completed within three weeks. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.</p> <p>Covid-19 risk management strategies has meant continuing periods of reduced access for visitors to the facility. Regular video sessions were held with families at these times.</p> <p>Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Feedback from the residents is gained through annual surveys and resident meetings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Initial care plans for long term residents reviewed were evaluated by the registered nurses within three weeks of admission. The GP has reviewed residents three monthly. Assessments for short term changes in health are added to the long-term care plan and removed when resolved. Files sampled demonstrated that the long-term nursing care plan was evaluated at least six-monthly or earlier if there is a change in health status. Progress notes reviewed identified regular reviews of residents.</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>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The GP and RN involve the resident (as appropriate) and relative in discussions around referrals and options for care. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented policies and procedures are in place for the management of waste and hazardous substances to ensure incidents are reported in a timely manner. Safety datasheets and products charts are readily accessible for staff. Chemicals are stored in a locked cupboard. Appropriate signage is displayed where necessary. Chemical bottles sighted have correct manufacturer labels. Personal protective clothing is available for staff and was observed being worn by staff when they were carrying out their duties on the day of audit. All staff have completed chemical safety training in November 2021.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires June 2022. The maintenance person was interviewed and works thirty-six week over four days and is available on call as required. He completes maintenance requests and repairs, planned maintenance and gardens and grounds. Staff request for repairs are either verbal or via the electronic patient management system. A record is maintained of all repairs by the maintenance person. There is a 52-week planned maintenance schedule in place and all maintenance undertaken is monitored by the care manager. Planned maintenance includes interior and exterior building, equipment checks, electrical checks and hot water temperature checks. Essential contractors are available 24 hours.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. Corridors and public areas light and spacious and residents can walk around freely. There is safe ramp access to courtyards and garden areas. Outdoor areas have wrap-around established gardens. Seating and shade are provided. The facility has two resident vans and a car that have current registration and warrant of fitness. One van is fitted with a wheelchair hoist.</p> <p>The caregivers interviewed stated they have sufficient equipment including mobility aids, wheelchairs, chair scales, hoists, and pressure injury resources (if required), to safely deliver the</p>

		<p>cares as outlined in the residents' care plans.</p> <p>Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All bedrooms throughout the facility have a handbasin. Two bedrooms have full ensuites. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. The fixtures fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Communal toilets and showers have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p> <p>Hot water temperatures are monitored monthly. When there have been hot water temperatures above the recommended safe temperature, action is taken and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The Pisa wing has two double rooms with one being shared by a married couple and the other with single occupancy. The Kowarau hospital wing has six double rooms. Three of these rooms are occupied with double occupancy shared agreements have been completed. The rest home has two double rooms that can be used for married couples, currently used as single accommodation rooms. The rooms provide adequate room for residents to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise their rooms. Rooms viewed were personalised with residents own furnishings and adornments as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large communal lounges and dining areas in both wings along with smaller areas including quiet lounges, a hair salon, a library, and a meeting room. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. External areas include a raised vegetable garden, a bird aviary and established garden area. There is a smoking area for residents outside of the building.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>All laundry is completed in site. Cleaning chemicals are securely stored in locked cupboards and are labelled. Cleaning and laundry policies and procedures are available. There are safe and secure</p>

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		<p>storage areas for cleaning equipment and chemicals and staff have access to these areas as required. Sluice rooms are available for the disposal of soiled water/waste. Handwashing facilities are available throughout the facility with alcohol gels in various locations.</p> <p>The laundry has a defined clean/dirty area. Linen and personal clothing is delivered to the laundry in covered buckets where it is sorted. Residents and a relative expressed satisfaction with cleaning and laundry services. There is protective personal clothing including eye goggles available. Laundry staff have completed chemical safety training.</p> <p>Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</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>	FA	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months (at a minimum). There is a New Zealand Fire Service approved evacuation scheme.</p> <p>The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. There is a diesel generator on site which operates all the hospital wing and some of the administration area. A gas cooker is available on the premises.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in proximity.</p> <p>There is a minimum of one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate. A first aid trained staff accompanies residents on outings.</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</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All bedrooms have adequate natural light.</p> <p>Individual bedrooms and communal areas are heated by adjustable radiators. The maintenance person interviewed ensures the centralised diesel boiler is running smoothly and that appropriate checks are performed. On the days of audit, the indoor temperature was comfortable.</p>

comfortable temperature.		Residents and families confirmed the facilities are maintained at a comfortable temperature during the summer and winter months.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator (RN) has a defined job description that outlines the role and responsibilities. The infection control programme is approved and reviewed annually. Infection rates are discussed at monthly staff and health and safety meetings. Staff are made aware of new infections through daily handovers on each shift and reporting,</p> <p>The IC programme is appropriate for the size and complexity of the service. Graphs of statistics and the quality meeting minutes are available to staff in the staff room.</p> <p>There are adequate hand sanitisers placed throughout the facility. Adequate stocks of personal protective equipment were sighted. There is an implemented Covid-19 management plan according to alert level guidelines include QR code contact tracing. A visiting protocol is in place to ensure visitors are well and free from exposure to illness.</p> <p>There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme and knew that they are required to report residents who are suspected of having infections to the RNs promptly. Staff were able to identify the importance of hand hygiene and using standard precautions.</p> <p>Covid-19 information is shared and accessible to all staff to read. Residents are closely monitored for any signs and symptoms. Personal protective equipment (PPE) was sighted.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator is responsible for infection control with support from the clinical manger and the care manager. The infection control coordinator has attended external education in the last year. The infection control coordinator has access to infection control personnel within the district health board, infection control specialist, laboratory services and the GP.</p> <p>Covid-19: A resource folder was maintained with all current information and guidelines to follow for each level of lockdown. The facility manager has compiled a file with specific instructions for each stage of Covid level alert changes. All screening was adhered to, and records maintained. The service has been compliant with guidelines and documentation requirements throughout the period. All visitors are required to complete a wellness declaration, check temperatures, and use the hand gel when signing into the facility. Staff, residents, and visitors are required to wear masks. The staff and residents have received Covid-19 and flu vaccinations. Staff were observed to adhere to good</p>

		<p>handwashing practices.</p> <p>The residents and relative interviewed felt they were updated regularly and was complimentary of the way the management and staff dealt with the lockdown at different levels. All stocks of personal protective equipment and outbreak equipment required is held centrally in the facility.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Ripponburn Home and Hospital has infection control policies and an electronic and hard copy infection control manual which reflect current practise and have been regularly reviewed. Policy, procedures, and the pandemic plan have been updated to include Covid-19.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>All new staff receive infection control education at orientation, including hand washing and an infection control questionnaire. Infection control education is included in the annual education planner. Education was held around donning and doffing personal protective equipment, handwashing, and outbreak management in April 2021.</p> <p>There is an infection control folder and the Covid-19 chart in the nurse's station for quick reference for any infection control events. Resident education occurs as part of care delivery.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection monitoring is the responsibility of the IC coordinator (the current ICC is resigning from the role and the care manager is providing support until a new ICC starts later this week). All infections are entered into the electronic database, which generates a monthly analysis of the data benchmarking against other similar services. There is an end of month analysis with any trends identified and corrective actions for infection events above the industry key performance indicators. There is monthly, three monthly and annual seasonal comparison of infection events. Outcomes are discussed at the combined quality/infection control/health and safety meetings, registered nurse, and daily handovers. The GPs also monitor and review the use of antibiotics. There has been a</p>

		<p>low incidence of infection since the previous audit.</p> <p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed with the facility manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint minimisation. A registered nurse is the designated restraint coordinator. Staff receive regular training on restraint minimisation. The caregivers interviewed were able to describe the difference between an enabler and a restraint. There were no residents using an enabler at the time of the audit.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint coordinator was not available to be interviewed and the clinical manager was interviewed in her place. Restraint minimisation policies and procedures describe approved restraints. A process is in place to approve restraints. At the time of the audit, bed rails and lap belts (prn) were in place for five residents identified as restraint. Restraint use is discussed in staff and RN meeting minutes. There were no residents using an enabler.</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, in collaboration with the staff RNs, is responsible for assessing a resident's need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. Assessment tools are in place for restraint use. Two residents' files where restraint was being used were randomly selected for review (one resident using bedsides, and one resident using bedsides and a (as-required) lap belt). Each resident using restraint has a restraint assessment completed. Family signs a consent for restraint use. The restraint assessment addresses risks associated with restraint use.</p>

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>A restraint register is implemented. The register, posted in the staff room, identifies residents that are using a restraint or an enabler.</p> <p>The restraint assessments reviewed identified that restraint is being used only as a last resort. Alternatives to avoid restraint use includes sensor mats, intentional rounding, regular toileting and encouraging residents who are at risk of falling to attend activities in the lounge. The restraint assessment process includes determining the frequency of monitoring while restraint is in use. Restraint policy indicates that all residents are monitored two-hourly at a minimum. Monitoring forms reviewed indicated that residents are monitored a minimum of two-hourly. Restraint use is linked to the residents' care plans with risks identified.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Restraint evaluations take place three-monthly, evidenced in the resident files where restraint was in use. Each evaluation determines the need to continue (or discontinue) restraint use. No incidents have been reported related to restraint use.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	<p>The restraint minimisation programme is scheduled to be reviewed annually. This review will include identifying any trends in restraint use, reviewing restraint minimisation policies and procedures, and reviewing the staff education programme. The service is actively working on reducing the number of restraints being used.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	Medication charts reviewed.	Three of six eyedrops were either undated or still in use past the expiry date. The controlled drug register had not always been reviewed weekly.	Ensure all eyedrops are dated on opening and discarded within required timeframes. Ensure the controlled drugs register reflects weekly checks.

				30 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>The RNs are responsible for all resident assessment and care planning. All residents had a care plan documented. The interventions documented did not reflect all resident current needs. Caregivers interviewed, were knowledgeable regarding resident needs.</p>	<p>Three of six care plans had not been updated to reflect care needs and/or did not reflect individualised care needs. This included (i) Three resident files documented behavioural issues however did not include individual management strategies. (ii) One resident had established social activities in place which were an integral part of his care however these were not documented in the care plan. (iii) One resident required oxygen therapy and detailed interventions on management of this were not included in the care plan.</p>	<p>Ensure that care plans document the individualised care needs for each resident.</p> <p>30 days</p>

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.

No data to display

End of the report.