

The Ultimate Care Group Limited - Lansdowne Court

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Lansdowne Court
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 April 2016 End date: 20 April 2016
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: 33	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ultimate Care Lansdowne Court is situated in Masterton in the Wairarapa region. It provides residential care for up to 34 residents who require hospital or rest home level care. Occupancy on the day of the audit was 33 residents; 15 at hospital level and 18 rest home level. The facility is operated by The Ultimate Care Group Limited.

This certification audit was conducted against the relevant Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, residents' and staff files, observations, and interviews with residents' families, management and staff. A nurse practitioner was also interviewed. Residents and family interviewed provided very positive feedback on the care and services provided by the facility.

The facility is managed by an experienced manager who has been in the position for eighteen months and is competently supported by the clinical services manager.

One area was identified as requiring improvement around documentation of restraint monitoring.

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.

Care provided to residents is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

There are no residents who identify as Maori at the time of audit, however appropriate policies, procedures and community connections ensure culturally appropriate support can be provided.

Residents interviewed feel safe, there is no sign of harassment or discrimination, staff communicated effectively and residents are kept up to date with information. Residents, or their enduring power of attorney, sign a consent form on entry to the service with separate consents obtained for specific events.

The service informs residents and their families of how to access the Nationwide Health and Disability Advocacy Service and encourage residents to maintain connections with family, friends and their community and to access as many community opportunities as possible.

An effective complaints system is in place with all response timeframes clearly documented. Any issues raised in the past year were low level and were resolved satisfactorily.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Ultimate Care Lansdowne Court is managed by an experienced and well qualified manager who oversees the day to day running of the facility. She is well supported by a regional manager and the quality management team at The Ultimate Care Group Ltd national office. Planning is detailed and is responsive to any changes required both at legislative and facility level.

A comprehensive quality and risk management system is in place with robust reporting. There is a quality improvement plan which includes an annual calendar of internal audit activity which monitors health and safety, infection control, medication, resident care, all administration functions, human resources processes and the monitoring of the quality initiatives that are in place. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective actions planning, feed into the quality improvement cycle to manage any further risk and ensure continuous quality improvement occurs.

A sound recruitment and appointment system is in place and staffing levels meet all the requirements. A comprehensive training programme is evident to maintain a high level of competence of all staff. Staff reported high job satisfaction and enjoy the supportive environment they work in.

Residents' information is accurately recorded, and all information was securely stored and not accessible to the public. Service providers used up to date and relevant residents' records.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The organisation works closely with the Needs Assessment Co-ordination Service to ensure access to the service is efficient and relevant information is provided, whenever there is a vacancy.

Residents' needs are assessed on admission by the multidisciplinary team. All residents' files sighted provide evidence that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility is very well maintained and provides an attractive and homely environment. The residents' rooms and the communal areas are spacious, clean, well ventilated and kept at a comfortable temperature for residents. The rooms all have ensuites, apart from two that share a bathroom. Well maintained and safe outside areas are easily accessed for all residents.

The building has a current building warrant of fitness.

The management of waste and hazardous substances is safely managed by staff who are trained in these processes.

Emergency procedures are well documented for ease of use and clear instructions, with relevant staff responsibilities, are located at all exits and by the fire alarms around the facility. Regular fire drills are held and sprinkler systems are installed in case of fire.

Adequate back up supplies and food are kept on site in case of an emergency and access to a generator is available if required.

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.

Some standards applicable to this service partially attained and of low risk.

The organisation has policies and procedures that meet all the requirements of the standard and these are followed for all enabler and restraints in use. Restraint is only used as a last resort when all other options have been explored and there is evidence that demonstrates the number of restraints in use has decreased over time. A comprehensive assessment, approval and monitoring process with regular reviews is occurring. The use of enablers is for safety of residents in response to individual requests. These are all reviewed regularly.

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 service provides an environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control nurse reporting directly to the clinical services manager who reports to the facility manager.

There is an organisation wide infection prevention and control programme, this is reviewed annually. An infection control nurse is responsible for this programme, including education and surveillance.

Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. Surveillance results are benchmarked within the organisation's other facilities and another large aged care provider. The results of surveillance are reported through all levels of the organisation, including governance.

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	49	0	1	0	0	0
Criteria	0	100	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	<p>Interviews with residents and family members of residents verified services provided complied with consumer rights legislation.</p> <p>Policy documents, staff orientation programme, in-service training records, education programmes, interviews with staff, and satisfaction surveys verified staff knowledge of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Clinical staff were observed to provide services of a standard that complies with consumer rights legislation.</p>
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	FA	<p>The informed consent policy describes all procedures to ensure the resident's rights to be informed of all procedures undertaken.</p> <p>Documentation, observation and interviews evidence information is provided to make informed choices. Informed consent is understood and is included in the admission process. The resident, and where desired family/whanau, are informed of changes in the resident's condition and care needs, including medication changes. Residents' choices and decisions, including advance directives, are recorded and acted on where valid.</p>

consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	The service recognised and facilitated the rights of residents and their family/whanau to advocacy/support by persons of their choice. The facility has open visiting hours. Residents' are free to access community services of their choice and the service utilised appropriate community resources, both internally and externally. Residents and their families are aware of their right to have support persons.
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	Residents are assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations, with the support of the service. The service acknowledged values and encouraged the involvement of families/whanau in the provision of care, and the activities programme actively supports community involvement.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>There is a complaints policy and associated forms that meet the requirements of Right 10 of the Code. These are provided in the first instance to all new residents on admission. Forms are also available in a number of areas around the facility. The facility manager takes responsibility for investigating and managing complaints. All complaints are recorded in the complaints register. A risk rating is applied to each complaint/concern and a risk matrix has been developed nationally to guide staff. Any of a serious nature are immediately notified to the quality manager who will then provide support if required. Every complaint is then entered into the electronic quality system (GOSH).</p> <p>The complaints register was reviewed and the two complaints received over the past twelve months were well documented with copies of all responses made. Both meet the required timeframes as per the organisational policy, were of a minor nature and resolved satisfactorily. The quality committee review any complaints at their monthly meetings. Corrective actions are initiated as appropriate and form part of the quality improvement process. In interview the manager also reported a number of compliments have also been received over the past year. These are also recorded and shared with staff.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Interviews, observations and documentation verified residents are informed of their rights. Information on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service are displayed and accessible to residents.</p> <p>Discussion, clarification and explanation on the Code and the Advocacy Service occurred at admission. Legal advice is able to be sought on the admission agreement or any aspect of the service. Information is provided on the facility's range of costs and services.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Policy identifies that procedures are in place to ensure residents are kept free from discrimination, harassment, abuse and neglect, including the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. Residents receive services which treat them with respect and has regard for their dignity, privacy, sexuality, spirituality and independence.</p> <p>Staff demonstrated policy awareness and responsiveness to residents' needs.</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>Documentation is in place to guide staff practices to ensure residents' needs are met in a manner that respects and acknowledges their individual cultural, values and beliefs. Policy states that this is to be identified upon entry as part of a resident's care planning process. The organisation had a documented Maori Health Plan which identified their priorities related to culturally safe services. The service recognises the relationship between iwi and the Crown and the principles of the Treaty of Waitangi (Partnership, Participation and Protection). Whanau relationships and involvement in care are recognised.</p> <p>The Maori health team from the District Health Board (DHB) supports the needs of Maori residents and will assist if required. There were no residents who identified as Maori at the time of audit.</p> <p>Staff receive education in relation to cultural safety and the Treaty of Waitangi.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally</p>	FA	<p>Policy identifies that residents receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values and beliefs.</p> <p>Evidence verified residents received and are consulted on culturally safe services which recognised and respected their ethnic, cultural and spiritual values and beliefs.</p>

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	<p>Policy indicates that residents are to be free from all forms of discrimination, coercion, harassment and exploitations. Orientation/induction processes inform staff on the Code. The company's house rules, policies and procedures provide clear guidelines on professional boundaries and conduct, and inform staff about working within their professional boundaries.</p> <p>Interviews verified staffs understanding. Residents felt safe and received a high standard of support and assistance and reported there was no sign of harassment or discrimination.</p>
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages good practice. Policies sighted are current, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies reflected current evidence based best practices, which are monitored and evaluated at organisational and facility level.</p> <p>Evidence verified a range of opportunities is provided to enable staff to provide services of a high standard. The nurse practitioner (NP) was interviewed and confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Policy identified that interpreter services are available and offered to residents with English as a second language. The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided. Communication with relatives is documented in the residents' communication records and incident forms and verified an environment conducive to effective communication.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	<p>Ultimate Care Lansdowne Court is part of a national organisation who have a chief executive officer (CEO) to manage an executive team to support their business activity. A chief operating officer manages the team that supports their aged care facilities based at the national support office. Each facility has its own annual quality and risk management plan written by the facility manager, which is informed by the national strategic and business plan and approved by the relevant regional manager. The vision, mission and goals of the organisation are clearly documented and these are integrated into the planning at each facility.</p>

consumers.		<p>These are reviewed by the executive team annually. A comprehensive suite of policy and procedure documents was sighted with the focus being on quality aged care provision. The quality and risk management plan details the facility's planned goals and actions for the current year.</p> <p>The manager reports to the regional manager with whom regular monthly meetings are held. The manager has been in the role for eighteen months and prior to that was employed at the facility for five years as an educator. She is a qualified enrolled nurse and has had significant experience in aged care.</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>Any absences by the manager are covered by the clinical services manager who has relevant experience to perform the role. There are a number of RNs who are also able to provide clinical coverage as required. The national team are also available at all times to provide any additional management support as appropriate.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a detailed quality and risk management plan which is reviewed annually. The current plan is for the 2016 calendar year. The organisation's value statement is "a promise to care" and this includes ensuring all facilities provide quality health and care services for everyone. The manager and clinical services manager run the quality improvement programme at the facility. There is a national quality governance group which includes consultation with the regional managers and each facility manager. A range of quality indicators are being monitored throughout 2016 with four indicators prioritised for the current year. For Ultimate Care Lansdowne Court these are medication, falls, behaviour and complaints. The other key components of the quality system include reporting and analysis of adverse events, infection control, health and safety, pressure injuries, weight loss, skin tears and wound management, property security, restraint, education and training and all quality improvement activities.</p> <p>The quality improvement plan includes an annual calendar of internal audit activity and the month when each audit is completed. The results of these are graphed and relevant corrective actions raised if needed.</p> <p>The quality management system is informed by regular reporting and analysis of data collected from all adverse events, complaints, infection control, health and safety and restraint minimisation. All information is fed into the national 'GOSH' quality system to enable national benchmarking and data analysis to be done at both facility and national levels. Collated reporting, including graphed information, is sent to the facility and these are reviewed at the quality meetings held monthly. Corrective actions are then put in place and monitored. Staff meetings are held monthly with quality indicators and issues discussed and any new</p>

		<p>quality initiatives introduced. Staff who are unable to attend must read and sign off the meeting minutes of both the quality committee and staff meetings. The minutes of the quality committee for the past three months are sighted and the agenda covers all the relevant quality and risk reports. Resident bi-monthly meetings also include relevant updates on quality initiatives as appropriate.</p> <p>The manager interviewed confirmed reporting on quality indicators is done on a weekly basis and this involves data around staffing levels, financial reporting and occupancy. Monthly reports are also completed including results from internal audits and the resulting corrective actions which are also monitored regularly.</p> <p>Policies sighted are all current with staged reviews occurring on a three year cycle. A document control system is in place. Any policies that change are sent to the facilities for updating. All staff must read all new and revised policies and sign when this has been completed.</p> <p>The facility risk register detailed risk factors, risk categories, impact and probability scales and impact of each after controls are applied, actions to be taken to control each risk and the people (positions and committees) responsible for them. These risks are reviewed continuously.</p> <p>All new hazards are entered into the GOSH system and each facilities hazard register is then automatically updated.</p> <p>Staff interviewed all report they are involved in and kept informed of all quality activity at the facility.</p>
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	<p>There is a detailed national policy on incident management and reporting. In the health and safety policies and procedures there is a guidelines document for reporting incidents / accidents. This describes the process for completing the incident / accident report form and what action staff take once they have completed the form. The policy on incident / accident reporting states that that any serious incidents / accidents are reported to head office. There are a range of other documents (policies, procedures and guidelines) to assist staff in investigating incidents and accidents and taking appropriate action.</p> <p>All individual events are followed up by the registered nurse on duty daily. They are then reviewed by the facility manager and details entered into the quality reporting system. There is monthly analysis of all incident / accident reports which are categorised according to each event type. This is sent back to the facility and the quality committee then review the collated data at their monthly meetings and raises any corrective actions that are required and monitors those already in place.</p> <p>The register was reviewed. Each form included documentation of notification of family and medical professionals where relevant. A copy was also filed onto the resident's notes. All relevant corrective actions raised are communicated to staff, reviewed, progress tracked and preventative measures implemented. All staff interviewed across all service areas understood they are responsible for reporting and responding to incidents and confirmed they understand and follow the required processes.</p>

		<p>The manager confirmed she reports any incidents that require essential notification to the relevant authority at the DHB or to the Occupational Safety and Health authority.</p>
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.	FA	<p>A comprehensive set of policies and procedures have been implemented nationally and reflect good employment processes. All recruitment is currently managed by the manager, with support from the CSM for all clinical appointments. The manager reports that when a vacancy occurs, head office manage the initial advertising then the responsibility for shortlisting, interview, reference checks and police checks is done internally by the facility. Competency checks are completed prior to any appointments. Professional qualifications are verified and filed. Other professionals who are independent of the facility as well as independent contractors also had relevant checks completed. All annual practising certificates (APCs) are current and securely filed. Current competencies for the facility interRAI assessors were sighted.</p> <p>The staff files reviewed have all the required documentation completed and current performance appraisals had been completed. Also included are training certificates for individuals.</p> <p>All staff have received a comprehensive orientation. This covered the introduction to the facility and the policies. New staff are also given an orientation book. This is required to be completed by the person over a three month period. They are then paired up with a more experienced staff member on a supervised buddy system for at least three days of duties. All staff interviewed confirmed their orientation process was completed and they felt able to carry out their duties as required, however they did suggest that new staff without previous experience may need additional support.</p> <p>A comprehensive annual training plan is in place. These covered all the requirements for aged care providers. The manager also reported she keeps individual attendance records to monitor the attendance of staff at all training sessions. The CSM is responsible for the clinical training programme and facilitates outside presenters as needed. All staff are required to attend training sessions directly associated with their role as well as full staff attendance at emergency evacuations training. There are a number of modules that are compulsory for all staff and this includes training about the Code, infection prevention and control, pressure injuries, manual handling, challenging behaviour, complaints and informed consent. Care staff are expected to complete Aged Care Education (ACE) training and the manager is a qualified assessor who manages this programme. She also provides mentoring for staff if they need this. Records reviewed evidence comprehensive training occurs for staff at the facility. A total of three registered staff are interRAI trained and pressure injury training has been completed by all care staff. Any staff unable to attend particular sessions must complete on line or paper based follow up training.</p> <p>Staff interviewed report they have significant training opportunities and confirmed management are very encouraging to staff to upskill themselves.</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>A national staffing rationale policy is in place. This describes the process for developing rosters in each facility. All rosters are maintained by the manager and are prepared two weekly in advance using the organisational tool. The tool is able to ensure safe staffing levels are in place as levels of need change and hours will be set according to the current needs of the residents at the facility.</p> <p>The rosters are sighted for the current week of the audit and also for the coming week. These confirm adequate cover for the acuity needs of current residents. The manager reports any absences are able to be covered as there are a number of casual staff able to be called on. At least one staff member on duty at all times has a current first aid certificate and there is 24 hour seven day a week (24/7) RN coverage.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>There was no personal or private resident information on public display during the audit. The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all resident's information sighted. Clinical notes are current and integrated with GP, NP and auxiliary staff notes. The files are kept secure and are only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical exam by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, national health index number (NHI), the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers are all recorded in each resident's record.</p> <p>Archived records were being held on site in a secure room. These are catalogued for easy retrieval.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>When the need for service had been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner.</p> <p>Information about the service, includes full details of the services provided, its location and hours, how the service is accessed and identifies the process if a resident requires a change in the care provided.</p> <p>Files reviewed contained completed assessments. Signed admission agreements met contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes.</p>

transfer from services.		
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.	FA	<p>The medication management policy is comprehensive and identifies all aspects of medicine management. A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Health care assistants are assessed to ensure they are competent to check out controlled drugs, in the absence of a second RN.</p> <p>Controlled drugs are stored in separate locked cupboards. Controlled drugs, are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.</p> <p>The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP or NP review is recorded on the medicine chart.</p> <p>There are no residents who self-administer their medicines.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident's medication chart. PRN medication requests include indications for use.</p>
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	<p>There has been a recent comprehensive analysis of the facility's food services by a food and kitchen consultant with input from the dietitian, to enhance the food services being offered. A new six weekly menu has been implemented which is in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu. Residents are offered a selection of choices for the evening meal every morning, choices are varied. Ongoing evaluation as to resident satisfaction with this menu is in progress.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted.</p>

		<p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored. A cleaning schedule is sighted as is verification of compliance.</p> <p>Evidence of resident satisfaction/dissatisfaction with meals and managements' actions taken to address some residents dissatisfaction, is verified by resident and family/whanau interviews, sighted satisfaction surveys, quality and resident meeting minutes.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.</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 clinical services manager (CSM) verified a process existed for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry is communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.</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>On admission, residents have their needs identified through a variety of information sources that includes the Needs Assessment and Service Coordination (NASC) agency, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident's bedroom.</p> <p>Over the next three weeks, the RN undertakes an interRAI assessment, which are reviewed six monthly or as needs, outcomes and goals of the resident change. In addition to the interRAI assessment, additional assessments are undertaken as clinically indicated, every three months for hospital residents and six monthly for rest home residents.</p> <p>A medical assessment is undertaken within 48 hours of admission and reviewed as a resident's condition changes, monthly or three monthly, by the GP or NP, if the GP documents the resident is stable.</p>

<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support the resident needs to meet their goals and desired outcomes.</p> <p>Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals. Notations are clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned.</p> <p>Care plans for hospital residents are evaluated three monthly and six monthly for rest home residents, or more frequently as the resident's condition dictated. Interviews and documentation verified resident and family/whanau involvement.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes. Residents and family/whanau members expressed satisfaction with the care provided.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p>
<p>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.</p>	FA	<p>Activities are provided by a qualified diversional therapist. Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. A van is available for residents to go out at least weekly. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.</p> <p>A residents' meeting is held two monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every three months for hospital residents and six monthly for</p>

		<p>manner.</p> <p>rest home residents, or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews, verified residents and family/whanau are included and informed of all changes.</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>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP, NP or RN sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the registered nurse or the NP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The national chemicals / hazardous substances protocol provides a number of instructions around handling chemicals, storage of chemicals / hazardous substances and procedure to be followed after any chemical / hazardous substance spill. The waste management policy requires adequate training, the use of data safety sheets, special considerations for Maori residents and the use of protective clothing. It has guidelines for handling and disposal of all chemicals and hazardous substances. Also within the infection control documentation is a waste management section which includes policy and procedures for waste (blood and bodily fluids) management and disposal.</p> <p>An external firm is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. In the locked cleaning storage area instructions for safe use was sighted. Cleaning products are all colour coded for ease of identification. The training records confirmed chemical and spill training is completed annually. The housekeeping staff interviewed were both able to detail process and procedures required for the safe use of all products for both the laundry and cleaning duties.</p> <p>Aprons, gloves and masks are provided in the sluice rooms and in all areas where personal cares are involved as well as the laundry and cleaning areas. Staff are observed using these throughout the facility as appropriate during the audit. A spill kit is stored in the sluice room.</p> <p>The exterior gardening shed had a locked cupboard where any insecticides or other hazardous substances</p>

		<p>are stored. The doors were well labelled with appropriate signage.</p> <p>Any incidents are reported and documented, then entered into the GOSH quality management system. Both clinical and non-clinical staff report they are clear about the process for incident reporting in this area.</p>
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The building warrant of fitness (WOF) was sighted and expires on 23 November 2016. All electrical equipment is checked and calibrated regularly with records kept in a register by the facility maintenance manager. Medical calibrations were checked in August 2015. Hot water temperatures are recorded monthly and any variations responded to.</p> <p>The hallways are wide enough to ensure any mobility aids are able to be stored without impeding access. All hoisting equipment is stored safely. Handrails are installed in all the hallways to assist with safe mobility.</p> <p>The outside areas are easily accessed and very well maintained. A number of residents were observed making the most of the sunny weather and sitting outside in the fresh air during the audit. Regular bar-b-ques are held during the summer months.</p>
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	All rooms except two have their own ensuites which are able to be used easily by residents of both levels of care. One bathroom is shared by those two rooms. All the facilities are hygienic and well maintained with privacy locks installed. There are also a number of additional toilets for residents and visitors to use in other parts of the facility. Clear labelling is used to identify these.
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	All the residents' rooms are fit for purpose and enable the safe use of any mobility equipment required. All are kept very clean and tidy with residents personalising their own environments according to their tastes. The rooms are all particularly spacious and residents spoken with expressed satisfaction with their rooms and the facility environment in general.

<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>The facility has two lounges provided for residents. One is quite large with a television and small kitchen for residents and families to use if they wish. A small library is set up there. It is also used as a venue for activities. A smaller lounge provides another communal quieter area and this can be used for small family gatherings. A large dining room is well set up, very sunny and meets the needs of the residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are specific laundry and cleaning policies which outline the aims and outcomes expected from the laundry services. There are procedures for the key tasks, times and frequency when these are carried out. The procedures for the treatment and cleaning of soiled laundry are clearly documented and clear definitions of the process for clean and dirty areas. Stained and/or damaged laundry and transportation of infectious linen is all detailed. There are internal audit tools for laundry and cleaning services and the most recent audits were reviewed and recorded appropriate effectiveness of both services.</p> <p>The laundry chemicals are all supplied by an externally contracted service who provides a monthly detailed service report, which includes temperature checking. They are all colour coded and well labelled. Training is given regularly to personnel involved in the laundry and cleaning. This is confirmed by relevant staff interviewed. The laundry manager is aware of all procedures should a spill occur and she reports all chemicals are carefully maintained by the maintenance person on a monthly, or as required basis. Machines are serviced regularly. All laundry is sorted into colour coded bags which separates the soiled and dirty linen and personal clothing. Any soiled laundry has been through the sluice room process prior to arrival at the laundry. Personal laundry is done in a separate machine. The process for washing linen is observed and follows the policy requirements.</p> <p>Product data sheets are displayed in the laundry area, which has the required doors for dirty and clean laundry, and well-marked areas for managing the separation.</p> <p>An externally contracted service also manages the cleaning supplies. They provide relevant training and cleaning staff interviewed confirmed this has occurred recently.</p> <p>The standard of cleanliness throughout the facility during the audit was observed as very high. All staff were observed using protective clothing during their work.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security</p>	FA	<p>There are polices / procedures and guidelines for emergency planning, preparation and response. There is a national civil defence plan document template which requires each facility to enter in their own local information with telephone numbers and addresses for the civil defence centre and emergency response</p>

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>centre, where and how much emergency water is held on site, the location of fire suppression equipment in the facility, the evacuation plan and assembly points. There are disaster planning guides which direct the facility in their preparation for disasters including earthquake, floods, storms, gas leaks and power outages. It also describes the procedures to be followed for fire evacuations and regular practices.</p> <p>The last fire evacuation drill was held on 12 November 2015. These are managed by an outside contractor and are held six monthly. No concerns were reported. The approved evacuation plan was sighted with approval dated 1994. Annual testing of the sprinkler system is undertaken and the alarm system is tested monthly.</p> <p>The emergency supplies are standard for the organisation and are stored in the facility and the outside storage area. Adequate emergency water is stored and this is changed six monthly. Pandemic boxes are also stored in the nurses' station. Cooking facilities include both gas and electricity. An outside gas bar-b-que can also be used if required. An emergency generator is available if needed.</p> <p>The electronic call system displays the relevant room number in lights in a number of areas around the facility to alert staff as to which resident is requiring attention. The manager confirmed informal audits are done by her to ensure calls are answered in a timely way. During the audit bells were observed to be answered very quickly.</p> <p>The quality committee monthly meetings discuss any safety and security incidents reported and also they ensure hazards are eliminated or controlled across the facility. Staff training in emergency evacuations is completed regularly and at all orientations. These are sighted as recorded and completed.</p> <p>The outside security gates are locked overnight and opened again around 6am. Security doors are in operation at the main entrance and all doors and windows are checked to ensure they are secure each evening.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Individual rooms and communal areas have large opening external windows and some also have doors that open onto outside areas. All bathrooms have electric fan ventilation. There is a large heat pump in the main lounge and all other communal areas have night store heaters. These are also located throughout the facility in the hallways with any additional heating in rooms is provided with oil heaters if required. All areas are well ventilated and temperatures during the audit were comfortable.</p>
<p>Standard 3.1: Infection control</p>	FA	<p>The infection prevention and control policy reflects the requirements of the infection prevention and control standard (NZS 8134.3:2008). The service provides a managed environment that minimises the risk of</p>

<p>management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme.</p> <p>The infection control programme, reviewed annually, establishes, maintains and monitors procedures covering infection control practices.</p> <p>The infection control practices are guided by the organisation's infection control manual, with assistance from the DHB infection control nurse where needed.</p> <p>It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted at audit. Reporting lines are clearly defined.</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 nurse (ICN) is responsible for implementing the infection control programme and reports directly to the clinical services manager (CSM). A position description for the role is included in the infection control (IC) programme.</p> <p>The ICN and observation verified there are enough human, physical and information resources to implement the infection control programme. The ICN is new to the role and is being supported by the CSM. Training records sighted and interview verified the CSM attends regular ongoing IC training with the ICN booked in for specific IC training with the DHB May 2016.</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</p>	FA	<p>The infection control programme includes the organisation's policies and procedures. Policies are current and signed off by company's clinical advisory group.</p> <p>Staff interviewed verify knowledge of infection control policies. Staff were observed to be compliant with generalised infection control practices.</p>

provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	<p>Interviews, observation and documentation verified staff have received education in infection control and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation.</p> <p>Resident education occurs in a manner that recognises and meets the residents' and the families' communication style, as verified by resident and family interviews.</p>
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	<p>In line with Health and Disability Services Standards (HDSS), infection prevention and control standard, surveillance of infections is occurring as per the surveillance guide, and is the responsibility of the infection prevention and control nurse.</p> <p>Incidents of infections and the required management plan are presented daily at handover, to ensure early interventions. Surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions. Data is fed into the organisation's database monthly.</p> <p>Incidents of infections are presented at the quality meetings and any ongoing corrective actions discussed and presented to staff at staff meetings, as evidenced by meeting records, infection control records and staff interviews. Incidents of infections are benchmarked with the organisation's other facilities and another provider.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>The organisation has a comprehensive suite of policies and procedures which meet the requirements of the restraint minimisation and safe practice standards with appropriate definitions provided. The restraint coordinator, who has been in the role for two years, provides support and oversight to the restraint management processes of the facility. In interview she demonstrated a sound understanding of the organisation's policies and procedures and these clearly guide practice.</p> <p>The policies and procedures emphasise that the use of restraint is a last resort and all alternatives are explored before restraints are used. This is also evident at interview with the restraint coordinator and on review of file records of those residents who have approved restraints and enablers. The use of restraints is minimised as much as possible while still maintaining safety.</p> <p>On the days of audit there were two residents using enablers. In both cases the residents have requested the equipment (bed rails) and a similar process to that followed for the use of restraints is used for enablers. This provides for a robust process which ensures the on-going safety and wellbeing of the</p>

		resident. In all cases the resident is voluntarily using the equipment and it is included in their care plan.
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	<p>There is a restraint approval process and a restraint approval group which is a part of the organisation's quality group. The group is made up of a range of staff from both nursing and care giving staff manager. The group meets regularly every month with a full organisational review and evaluation meeting six monthly. The resident's general practitioners are also a part of any approval and review process.</p> <p>Restraints are used for safety only. Records were reviewed and confirmed that the restraint coordinator, a registered nurse, has accountability and responsibility for restraint processes at Ultimate Care Lansdowne Court. The organisation's processes are implemented and the approval process is followed.</p> <p>On the days of audit there were five residents with approved restraints. It was evident from review of quality meeting minutes and collated data that the overall use of restraints is being carefully monitored and analysed and that use of restraints has reduced in the last year.</p> <p>There is a position description for the restraint coordinator which describes the role and responsibilities. The meeting minutes and records on residents' files demonstrated that the restraint coordinator has been undertaking the role as described.</p> <p>Residents who have approved restraints have all the appropriate approval documentation on their files. Their care plan includes reference to the current approved restraints in use. There is also evidence of family/whanau/EPOA involved in the decision making as is required by the organisation's policies and procedures.</p>
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	<p>The assessment process includes all requirements of this standard. The initial assessment is undertaken by the clinical team with input from the resident's family/whanau/EPOA. The general practitioner is always involved in the final decision on the safety of the use of the restraint.</p> <p>The assessment process includes consent from the resident's family/whanau or EPOA, whoever is most appropriate. All residents using restraints at the time of the audit have a current assessment and consent form. All historical information and comments from any referrers are included in the assessment process as are any cultural considerations.</p>
Standard 2.2.3: Safe Restraint Use	PA Low	The use of restraints is actively minimised. At interview with the restraint coordinator, she described how alternatives to restraints are discussed with family/whanau when they request restraints. Time is spent explaining how the resident can be safely supported and alternatives explored before use of a restraint is

Services use restraint safely		<p>implemented.</p> <p>Restraint approvals and relevant discussions in the quality group meeting are recorded in the minutes. Family/whanau interviewed confirmed they are included in decision making.</p> <p>A restraint register is maintained by the restraint coordinator. It is updated every month and reviewed at every quality group meeting. The register for all the current residents was reviewed. The register has been maintained throughout this time. Changes on the register reflect any changes in need that are identified. Three residents' restraints have been discontinued over the past six months.</p> <p>Staff members interviewed reported that restraints are used as a last resort and only to ensure safety. They receive training in the organisation's policy and procedures and in related topics such as supporting people with challenging behaviours in positive ways. Their understanding is that the use of restraints is to be minimised as much as possible. Monitoring documentation is not being completed consistently.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>The restraint team evaluates the use of restraints for every resident at least monthly. This includes a review and updating of the documentation relating the use of the restraint and feedback from all staff members involved in the providing care and support to each resident. Any changes since the last review are considered with the possibility of removing the restraint discussed for each person and carefully considered.</p> <p>All requirements of this standard are included in the evaluation of restraint use and are documented on each resident's file. This was confirmed on review of files during this audit.</p> <p>When restraints are in use they are monitored frequently to ensure the resident remains safe, however some of this is being completed informally without the required monitoring reports being completed (refer 2.2.3.4).</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 manager and relevant clinical team undertake a six monthly review of all restraint use which includes all the requirements of this standard. Additional information is included in the quality committee minutes meeting which has benchmarked data and graphs of restraint use over time with other Ultimate Care Group facilities and externally over the past six months.</p> <p>The restraint monitoring and quality review documentation was reviewed for the past twelve months. The trend is for decline in the use of restraints as previously noted. Interviews with staff members confirmed their understanding of a focus on safety, wellbeing and reducing the use of restraints as much as practicable.</p>

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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint;	PA Low	The monitoring requirements with the frequency of that monitoring is detailed on the appropriate consent and assessment forms. It is commonly two hourly. However the documentation is not being consistently completed by staff on the relevant recording forms to reflect when this monitoring is actually occurring. Staff report they are working closely with those residents, with frequent observations ensuring the restraints are in place safely, but that documentation of those observations is not always completed. Families reported there have been no concerns. All files reviewed	There is inconsistency in the required documentation of the monitoring which is occurring during all episodes of restraint and enabler use.	Provide evidence that the monitoring is being consistently documented for all residents who are using restraints and enablers.

(f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.		evidenced inconsistent recording.		180 days
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this audit.

No data to display

End of the report.