

# Melody Enterprises Limited - Ultimate Care Rhapsody

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Melody Enterprises Limited
<b>Premises audited:</b>	Ultimate Care Rhapsody
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 9 March 2016    End date: 10 March 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	68

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Ultimate Care Rhapsody provides rest home, hospital medical and hospital geriatric services for up to 70 residents. It is operated by Ultimate Care Ltd.

This certification audit was conducted to the Health and Disability Services Standards and the service's contract with the Taranaki District Health Board. The audit process included review of policies and procedures, residents' records and staff files, observations, interviews with residents, family/whanau and staff members, the facility and clinical services manager, two managers from Ultimate Care's national support office, and a general practitioner.

There are no areas requiring improvement identified. There is one area of particular strength identified in relation to the activities programme.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Care provided to residents is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

There are residents who identify as Maori at the time of audit, and appropriate policies, procedures and community connections ensure culturally appropriate support is provided.

Residents interviewed feel safe, there is no sign of harassment or discrimination, staff communicate 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 encourages residents to maintain connections with family, friends and their community and to access as many community opportunities as possible.

A complaints register is maintained by the facility manager and includes all actions taken and the status of each complaint. The complaints process is easily accessed within the facility and staff receive appropriate training.

## 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 is a privately owned organisation. There is a governing body with an executive management team and a national support office which provides both operational and clinical oversight to all Ultimate Care facilities across New Zealand, including Rhapsody. There is an annual strategic plan and business plan which describes governance and management structures.

The Rhapsody facility manager provides weekly reporting and there is close monitoring by the regional manager and the clinical management team who are based at the national support office. The facility manager is for the overall management of the facility

and non-clinical staff. There is a clinical services manager who is responsible for the clinical services. All the nursing and caregiving staff members report to this person.

In a temporary absence of the facility manager the clinical services manager will act in her place with support from the regional manager and a senior registered nurse acting for the clinical services manager. In a temporary absence of the clinical services manager a senior registered nurse will act in his place, with support from the clinical management team at national support office.

Ultimate Care has a well-developed quality management system. The facility manager is responsible for ensuring that it is implemented at Rhapsody. Quality improvement and risk management systems are well implemented. Staff members understand their roles and responsibilities in the quality system. All adverse events are reported and recorded. Collated event data is discussed at a range of meetings so that trends and issues can be identified and addressed. There is a clear process for escalating moderate to high risk events and issues to the national support office.

Policies and procedures are maintained and controlled centrally from Ultimate Care's national support office. Updated and newly released documents are made available electronically to the facility, and the two managers are responsible for ensuring that staff are aware of these changes.

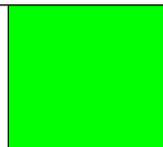
There are effective processes for the safe recruitment and appointment of staff members. A review of personnel files confirmed that employment practices at Rhapsody are compliant with the organisation's systems. There is an annual training calendar which includes all requirements of these standards and the service's contract. Staff have access to appropriate training.

Rostering of all staff in the facility is completed by both the facility and clinical services managers using the Ultimate Care's documented rational for safe staffing. This ensures there are sufficient numbers of staff on duty to meet residents' needs. There are 24 hour nursing staff on duty in the facility and additional senior nursing staff are available on call.

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.

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 provided 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.

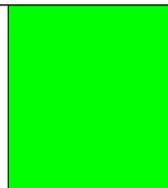
An activities programme exists that is resident driven and offers a variety of resident initiated activities and includes involvement with the wider community. The inclusion of residents' in planning, monitoring and review of the activities is identified as a particular strength of the facility.

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

The menu has been reviewed by a registered dietician 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.

Rhapsody is a purpose built aged care facility. The whole facility is on one level and there is easy access in and out of the building throughout.

Ultimate Care's documented procedures for the management of waste and hazardous substances are available at Rhapsody. These are included in training for house-keeping staff members and on display in relevant utility rooms.

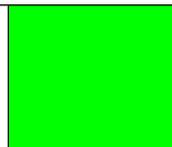
There is a current building warrant of fitness and appropriate checks are conducted regularly to ensure the environment remains safe for residents. A preventive and reactive maintenance programme is undertaken by an onsite contractor which includes all requirements of these standards. The contractor was interviewed during the audit and demonstrated their understanding of the monitoring and checks needed to maintain the environment.

All residents' rooms and spaces have necessary furnishing, windows, ventilation and heating to provide a comfortable, safe and pleasant home. Residents and family/whanau interviewed talked about 'loving their home' at Rhapsody. The facility is well maintained, clean, odour free and tidy. Residents were observed to be moving around the facility independently, with mobility equipment and with assistance as needed during the days of audit.

All necessary security and emergency response procedures are in place.

## 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.

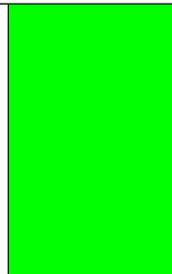
Policies and procedures guide the restraint coordinator and approval group in the safe use of restraints and enablers. The restraint coordinator has a position description and she is supported by the clinical services manager to ensure that there is an emphasis on the reduction in restraint use. All use of enablers is voluntary.

The residents using enablers and restraints on the days of audits were doing so as required by the organisation's procedures. All appropriate monitoring, evaluation and review of restraint use occurs as required.

Staff interviewed understood the procedures for minimising the use of restraints and focus on residents' safety. Records reviewed indicated that family/whanau are involved in decision making.

## 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 coordinator reporting directly to the facility manager and the chief clinical officer.

There is an infection prevention and control programme for which external advice and support was sought; 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 was 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. 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	50	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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	Policy documents, staff orientation programme, in-service training records, education programmes, interviews with staff, residents and family members of residents, satisfaction surveys and observation verified services provided complied with consumer rights legislation.
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 informed consent policy describes all procedures to ensure the resident's right to be informed of all procedures undertaken.  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.
Standard 1.1.11: Advocacy And	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

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>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 and representatives from the Nationwide Health and Disability Advocacy Service meet with residents and staff at least yearly.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents 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.</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>Ultimate Care has an appropriate complaint management policy and procedure which meets the requirements of the Code and this standard. This is made available to the resident's family and whanau on entry to the service. Staff members receive training in the process at orientation and a refresher at the annual study day.</p> <p>An electronic register and complaint form is used to report and record complaints formally through the organisation's GOSH incident/accident/complaint/compliment reporting system. This was reviewed with the facility manager during the audit. It was up to date and reflected the action taken to respond to the complaints received. Hard copies of complaint forms and other correspondence are maintained and timeframes are met. There is escalation of complaints to the regional manager and clinical team at Ultimate Care's national support office based on risk, when necessary.</p> <p>Records of complaints from 2015 and 2016 were reviewed with the facility manager. Complaints have been responded to as is required by the organisation's policy and the intent of the Code. Staff members interviewed spoke about the importance of listening to resident and family/whanau concerns and ensure that they are given options to resolve these. This may be formal complaints or opportunities to discuss issues and reach a resolution or both. Advocacy services have been accessed for residents when necessary.</p> <p>Residents and family/whanau interviewed confirmed that they are satisfied with complaint resolution and responses.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</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</p>

<p>Consumers are informed of their rights.</p>		<p>Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service is displayed and accessible to residents.</p> <p>Discussion, clarification and explanation on the Code and the Advocacy Service occurs 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>	<p>FA</p>	<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>	<p>FA</p>	<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. The organisation has a Maori health plan, a Maori health policy, Maori perspective on health, and cultural safety policy. The Maori health plan, includes the three principals: partnership, participation and protection, and describes how the holistic view of Maori health is to be incorporated into the delivery of services.</p> <p>A resident who identifies as Maori verifies opportunities are provided to:</p> <ul style="list-style-type: none"> <li>• have an iwi, hapu and/or whanau representative contacted and present whenever required, including assessment and review of care.</li> <li>• have an interpreter when requested.</li> <li>• have resident information in te reo Maori where requested.</li> <li>• be assisted to find culturally appropriate agencies when requested.</li> <li>• have a nominated Maori representative to respond verbally or in Maori to the annual Resident Satisfaction Survey or in dealing with a complaint or concern.</li> <li>• special food requests if possible.</li> <li>• assistance in provision of rongō Maori if requested, in consultation with the medical practitioner</li> </ul>

		<p>The local Maori consultation service supports the needs of Maori residents and will assist if required.</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 safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</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>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	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 staff understanding of the house rules and Code. Residents felt safe and receive a high standard of support and assistance and reported there was no sign of harassment or discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages good practice. Policies sighted are current, relevant and referenced to related sources, legislation and the Health and Disability Services Standards 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 are provided to enable staff to provide services of a high standard. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive</p>	FA	<p>Policy identified that interpreter services are available and offered to residents with English as a second language.</p> <p>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</p>

to effective communication.		documented in the residents' communication records and incident forms and verified an environment conducive to effective communication.
<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>Ultimate Care is the governing body of the organisation. It is privately owned and operates services across New Zealand. There is an executive management team which includes a chief executive and chief operating officer. Each facility has support from a regional manager and the clinical support team. The regional manager provides operational management oversight. The clinical support team provide clinical support, incident/accident management and response, clinical governance and audit and compliance support.</p> <p>The group has systems and processes which define the scope, direction, goals and values of the organisation. These are on display at Rhapsody and are contained in the strategic documents reviewed during the audit. These documents are reviewed and updated annually. During interview with the facility manager and the audit and compliance manager, both described the organisation's processes for this.</p> <p>This is the facility manager's first management role. She has held the position since January 2015. Since that time she has completed the organisation's new manager's orientation programme and received support and mentoring to transition into the role. The organisation has developed a management development programme and this is being delivered in 2016 over five months from March to July. The programme includes the key components of management and leadership and requires project work between three offsite learning modules. The facility manager has also attended local management training opportunities which occurred externally to Ultimate Care and Rhapsody, as well as taking part in the organisation's other management development initiatives.</p> <p>Rhapsody provides rest home, hospital medical and hospital geriatric services for up to 70 residents. On the days of this audit there were 68 residents, 21 hospital level and 47 rest home level. The facility holds contracts for the provision of aged residential care and palliative care services.</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</p>	FA	<p>All Ultimate Care facilities are managed by a facility manager and clinical services manager as a management team. The facility manager has overall responsibility and clinical services manager is responsible for the health and wellbeing of residents and nursing and caregiving staff members.</p> <p>In a temporary absence of the facility manager the clinical services will be the acting facility manager, with support from their regional manager. In a temporary absence of the clinical services manager, an experienced member of the registered nursing team will be acting as the clinical services manager, with support from the clinical support team at the national support office. (At the beginning of</p>

<p>safe services to consumers.</p>		<p>February 2016, Rhapsody employed an experienced registered nurse who will be able to provide this back up for the clinical services manager. See standard 1.2.8 for more information.)</p> <p>At interview with a range of staff members they report that the management team are approachable and that things are more settled and stable.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has templates for quality and risk management plans. The facility manager develops these annually with specific objectives for the facility and they are signed off by national support office. Nationally there are clinical and non-clinical quality indicators which are also included in each facility's quality plan. These indicators include incidents, accidents, infections, restraint and enabler user, complaints and compliments, staff accidents and incidents. Monthly data is collated and graphed and reported to staff members through the general monthly staff meeting as well as the registered nurse/enrolled nurse meeting, the health and safety and quality meeting, the infection control and restraint approval group meetings. Either the facility manager or the clinical services manager run these meetings.</p> <p>At the end of 2015 Ultimate Care commenced benchmarking with another national aged care provider. Each facility received their own collated quality indicators, collated data from all Ultimate Care sites and collated data from the other provider. This benchmarking will now continue quarterly. The facility manager reported that it was very useful. Meeting minutes and other records were reviewed which demonstrate that the benchmarking information is utilised.</p> <p>A range of staff members interviewed reported that collated quality data is discussed at a range of meetings in the facility. Meeting minutes were reviewed and confirm this. Minutes record meaningful discussions with involvement from staff members.</p> <p>The facility manager sends weekly and monthly reports to national support office through the electronic reporting system on occupancy data, staffing and the quality plan clinical and non-clinical indicators. By this mechanism progress against the quality plan is monitored closely and frequently. Variations are reported verbally as well as through the electronic system. Quality meeting minutes include the clinical and non-clinical indicators as well as discussion of relevant issues, activities taking place in the facility, new initiatives and results of internal audits which have been completed since the last meeting.</p> <p>Corrective actions are identified in relation to individual incidents/accidents/complaints, as well as internal audits. A range of corrective actions and evidence of implementation, monitoring and follow-up were reviewed during the audit. These are all recorded through the GOSH system, as well as the original adverse event/internal audit. Follow-up from the national support team may occur through on line monitoring, telephone conversations or onsite visits from the regional manager (at least monthly)</p>

		<p>or a member of the clinical support team depending on the requirement.</p> <p>A risk register is maintained at Rhapsody by the facility manager. This is a combination of organisation wide business risks and facility specific business risks. The register is monitored at appropriate intervals and risks are escalated when necessary. At interview the facility manager demonstrated a clear understanding of the purpose and processes for risk management which are available to her. The records reviewed demonstrated that these are used, updated and amended as and when needed.</p> <p>The organisation's documented policies and procedures are maintained by the clinical support team. All documents are reviewed on a regular cycle and are current on the days of audit. Staff with skills, knowledge and experience relevant to the subject of a policy are involved in its development or review. New or amended policies and procedures are made available electronically the facility manager and the clinical manager. They will then update hard copies of the policy and procedure manuals for staff members with no computer access. A folder is maintained in the staff room with newly issued documents for staff to review and sign off. This was reviewed and had several new policies and documents in it. Staff meeting minutes also include updates on new documents at each meeting. All documents reviewed prior to and during this audit were current, controlled and meet the requirements of these standards and the contracts held by the provider.</p> <p>It is noted that the organisation has a pressure injury prevention and management policy and procedure which provides clear guidance for staff on the prevention of pressure injuries, and management of them if they develop. There is a clear statement that all pressure injuries are to be reported as incidents.</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>	<p>FA</p>	<p>The adverse event reporting system provided evidence of a planned and coordinated process. Staff document adverse, unplanned or untoward events on incident / accident forms which are then report to Ultimate Care's national support office through the GOSH electronic system. The original form is filed on the resident's file and the facility manager maintains the electronic GOSH 'register'. This is visible at the facility and at national support office. All incidents are collated, reviewed and analysed at the monthly quality meetings. Corrective actions are identified to improve service delivery and to mitigate risks.</p> <p>The GOSH register was reviewed from late 2015 to the date of this audit and a sample of adverse events were reviewed. This included the pressure injury noted in standard 1.3.3 and reported under section 31 to HealthCERT on 2 March 2016. This had been reported as a pressure injury, as is required by the organisation's policy on pressure injury prevention and management (PIPM). When the injury was noted as 'unstageable' and so required reporting under section 31 to HealthCERT, this was reported to the chief clinical officer so that this could occur. Again, as is required by their PIPM</p>

		<p>policy.</p> <p>There is clear information about other essential notifications. Most are undertaken by the chief clinical officer due to the escalation or risk processes in the GOSH system. The facility manager was familiar with her responsibilities for reporting events which require essential notification.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The facility manager undertakes all recruitment with either the clinical services manager, the head cook or the laundry and cleaning supervisor depending on the location of the vacancy. Appointment of nursing team members is always signed off by the regional manager and clinical support team. Prior to and after appointment, the facility manager validates and monitors the practising certificates for medical and allied health service providers at the facility. A register of practising certificates is maintained and was reviewed. All nursing staff, general practitioners and allied health providers who work in or provide services to the facility are currently registered by their professional organisation.</p> <p>Ultimate Care has a comprehensive suite of human resources management policies and procedures and these include the recruitment and appointment of employees and contractors. A sampling of personnel files and interview with the facility manager confirmed that these systems are implemented at Rhapsody. All staff have appropriate pre-employment checks as well as interviews. There are employment agreement and induction and orientation programmes which are recorded on personnel files. At interview with a range of staff the reported that their orientation included an appropriate introduction to the organisation and their role.</p> <p>There is an annual training plan developed by the facility manager. This includes all the requirements of these standards and the contracts. The facility manager has implemented an annual study day which is held three times a year. Staff are assigned to attend one of these three sessions and complete all the basic refresher training on this day. Additional in service training is held throughout the year during staff meetings, for different groups of staff and when required for different issues.</p> <p>The clinical services manager maintains an additional training programme for the nursing and care giving staff members. For 2016 this includes the Hospice New Zealand nine palliative care modules. He also maintains a schedule of competencies for both the nursing and care giving staff which includes medications, syringe driver use, restraints, hand hygiene and hoist use. Competencies are current as possible given the time of year. The clinical services manager is the link nurse for the Hospice and as well as attending their meetings attends training and information sessions run for the link nurse group.</p> <p>Staff members interviewed report that the annual study day is great initiative. They can then attend other sessions as they are able to through the year. Competencies and training completion records for 2015 were reviewed with the facility manager. These were current and completed. The training</p>

		<p>calendar has so far been implemented.</p> <p>All care givers complete the Aged Care Education (ACE) certificates. All care givers on staff currently hold this certificate.</p> <p>The audit and compliance manager has been the interRAI assessment coordinator for Ultimate Care. She is able to provide on-the-job coaching for nurses when they complete their training. Currently five of the nurses as well as the clinical services manager are interRAI trained and competent. Although this is not their ideal it is as many as can currently be trained. Additional nursing staff are waitlisted for training. They are able to keep all residents Long term care facility (LTCF) interRAI assessments up to date with this number of nursing staff interRAI competent.</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>Twenty four hour nursing cover is provided. The clinical services manager rosters the nursing and caregiving staff and the facility manager rosters all other staff. This follows Ultimate Care's policy - Allocation of staff duty rosters.</p> <p>A roster is prepared, fortnightly in advance, which provides cover for the facility across the rest home and hospital areas, with appropriate ratios of registered nurses, enrolled nurses and caregivers across the three shifts.</p> <p>Additional house-keeping staff ensure that the environment is clean, tidy and well maintained. There is an experienced head cook and additional kitchen staff. Activities are provided by two activities coordinators who work Monday to Friday and provide a varied programme. All gardening and maintenance activities are now conducted by external contractors who are based on site.</p> <p>As noted in standard 1.2.2, Rhapsody has recently appointed an experienced registered nurse to provide back up to the clinical services manager. He is currently on call at all times when he is not on duty. He and the facility manager have been looking at the skills of the nursing team and deliberately recruited two experienced registered nurses, with one who will be able to be his 'deputy'. Adding these two more experienced nurses to the team ensures they have a balance in their nursing team between experienced and newly graduated nurses.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible</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 and auxiliary staff notes. The files are kept secure in each wing and 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</p>

when required.		<p>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 transfer from services.</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>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is comprehensive and identifies all aspects of medicine management.</p> <p>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, as are staff who check the medication being administered is correct.</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 review is recorded on the medicine chart.</p> <p>Residents who self-administer their medicines have appropriate processes in place to ensure this is managed in a safe manner.</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 was 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 includes indications for use.</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>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.</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, is sighted.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p> <p>The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification of compliance.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys 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>
Standard 1.3.2: Declining	FA	An interview with the clinical services manager (CSM) verified a process existed for informing

<p>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>		<p>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>	<p>FA</p>	<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 or the whanau room with the resident and/or family/whanau present if requested.</p> <p>Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed three monthly or as needs, outcomes and goals of the resident change. A medical assessment is undertaken within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. A multidisciplinary assessment is undertaken yearly.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<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, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned.</p> <p>Care plans are evaluated six monthly 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</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes.</p> <p>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</p>

desired outcomes.		guidelines and met the residents' needs.
<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>	FA	<p>Activities are provided by a diversional therapist and experienced activities co-ordinator. 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 promotes quality of life through the provision of varied physical and mental opportunities that are meaningful to the resident. The programme is planned in consultation with residents, their advocates, family/whanau, nursing personnel and management with the goal being to support residents' past interests, relationships and participation in the community. Numerous ideas and activities suggested by residents are included in the programme, and the residents assist in the event planning, monitoring and review of ongoing activities. 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 monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that residents' suggestions and involvement is an integral part of the programme that is offered. Interviews verify feedback is sought and satisfaction with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</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 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</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 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 GP. The resident and the family are kept informed of the referral</p>

<p>referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>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>	<p>FA</p>	<p>The organisation's protocols and guidelines for the management of waste and hazardous substances are available to the house-keeping team and on display in relevant work areas. These meet the requirements of these standards.</p> <p>All hazardous substances and chemicals are stored safely and securely, both when in use and when stored. Material safety data sheets are available on site for the cleaning and laundry products in use at Rhapsody.</p> <p>Staff members interviewed had received training in the use of the products used in the facility and adequate supplies of personal protective equipment (PPE) in their work spaces. Additional stocks are available in storage areas. Specific PPE is available for outbreaks and for use in some designated areas. Staff members were observed wearing and using appropriate PPE during the audit visit.</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>	<p>FA</p>	<p>There is a current building warrant of fitness for the facility. This was seen with the manager and is on display. All associated checks and routine monitoring occurs in relation to the warrant.</p> <p>The facility has been purpose built for the population and is suitable for the residents' needs. It is on one level throughout. Transitions through doorways, internally and externally are flat. There are handrails in all corridors and the flooring is of low rolling resistance for residents who use mobility aids. A large number of residents were observed moving independently throughout the facility during both days of the audit.</p> <p>The design of the building provides for external access in a number locations. There are well maintained gardens and the facility is surrounded by lawn with trees and bush on the perimeter of the property.</p> <p>Residents and family/whanau interviewed report that their satisfaction with the whole environment and that it is safe and meets their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>There are sufficient toilets, hand washing, showering and bathing facilities for residents in the facility. These are provided in a mix of full ensuite bathrooms in 30 bedrooms, and wash hand basins (15 bedrooms) or an ensuite toilet and wash hand basin (19 bedrooms).</p>

<p>adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>The 30 bedrooms with full ensuite bathrooms are used by rest home level care residents. The other 34 bedrooms with the mix of washing and ensuite toilets are used by hospital level care residents. These residents share nine communal shower bathrooms, all of which are in close proximity to these bedrooms.</p> <p>The residents who occupy the 15 bedrooms without an ensuite toilet have access to eight toilets which are located in close proximity to these rooms. In addition to these residents' toilets, there are three designated toilets available for visitors and staff throughout the facility.</p> <p>All shower bathrooms, ensuites and toilets have non slip flooring and appropriately placed handrails. Mobility equipment for safe showering is provided.</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>All bedrooms at Rhapsody are very large. Rooms can easily accommodate the resident's bed, furniture and personal items, as well as any mobility equipment, hoists or other assistive equipment which may be needed for their safety and comfort. All rooms for residents at hospital level care have widened doorways and corridors are wide enough to accommodate the person being moved.</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 a mix of large and small communal areas within the facility. There is one large dining room adjacent to the kitchen and a medium sized dining room elsewhere in the facility, near the bedrooms for residents who require hospital level care.</p> <p>There is a very large living / activities / sitting room used during week days for any organised activities. In several places around the facility there are sunny, living room type areas with comfortable chairs which are used for watching television, reading, puzzles or hand work. In the large foyer / reception area there is a seating area with a group of comfortable chairs. This is used as a meeting and conversation area and was used by a changing group of residents during the days of the audit.</p> <p>There is a 'men's shed' at the back of the facility, and some external seats and work areas which are part of the activities programme.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe</p>	FA	<p>Two members of the house-keeping team were interviewed during the audit. Both report informally checking the standard of their cleaning and laundry and effectiveness of the products, while they are working. They use checklists to record the work done on any given day, so that their work can be</p>

<p>and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>monitored by the house-keeping supervisor and the facility manager.</p> <p>Internal audits are used to formally monitor the effectiveness of cleaning and laundry. These are completed quarterly. The audits for the last six months were reviewed with the facility manager. She will either complete these audits herself or delegate the audit to another staff member to complete. However she reports always carrying out her own informal monitoring.</p> <p>At interview with staff members they report that residents and family/whanau frequently comment on the cleanliness and tidiness of the environment. This is confirmed through interviews with residents and family/whanau during the audit process.</p> <p>Each cleaner's trolley has a small locked box for the storage of cleaning products when the trolleys are in use. Additional supplies of cleaning and laundry products are stored securely in all utility rooms.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The orientation and annual study day both include training on fire evacuation and response, security measures and emergency preparedness and response for all staff members. Review of personnel files with a random sampling across functional teams confirms that training is current. At interview staff are clear about their responsibilities for action in the event of a fire evacuation and where to access information in an emergency.</p> <p>There is an approved evacuation plan for the facility and there have been no alterations since the plan was approved. Copies of the fire evacuation plan are on display throughout the facility, and fire suppression and response equipment is also available.</p> <p>Alternative energy and utility sources are available on site in the event of a civil defence emergency. This includes an onsite water storage tank, generator and alternative cooking facilities with sufficient supplies of gas for the facility to be self-sufficient for several days before additional supplies are required. A comprehensive plan is in place which includes a memorandum of understanding with another local facility to share facilities should this be required.</p> <p>There is call system which is activated by the resident. Care plans record instructions for the call button to be accessible and activated alarms were responded to promptly during the on-site audit. There were no recorded incidents or complaints or non-responses to the call system.</p> <p>The facility manager described the security arrangements which incorporate locking the external doors overnight and monitoring of these by the night staff. There is an overnight patrol by a volunteer business association in New Plymouth. This occurs randomly during the night, every night.</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>The facility has gas central heating with separate vents into each room and bedroom. All resident occupied rooms and bedrooms have generous external windows, which allow natural light and have at least one opening section for ventilation.</p> <p>All windows have ample window coverings which are in good condition and provide adequate shade when needed, and insulation in winter.</p> <p>One of the days of the audit was very warm and the facility was kept at a comfortable temperature with open windows allowing ventilation.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. 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 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 clinical services manager is the infection control nurse (ICN). The ICN is responsible for implementing the infection control programme, and reports directly to the facility manager and the chief clinical manager. A position description is included in the infection control (IC) programme.</p> <p>Interview with the ICN, sighted documentation and observation verified there are enough human, physical and information resources to implement the infection control programme. Training records sighted and interview verified the ICN attends regular ongoing training.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current</p>	FA	<p>The infection control programme includes policies and procedures that are formulated at organisational level and reflect current good practice and legislative requirements. Policies are current.</p> <p>Staff interviewed verify knowledge of infection control policies and were observed to be compliant with generalised infection control practices.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verify 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.  Resident education occurs in a manner that recognises and meets the residents' and the families' communication style, as verified by resident and family interviews.
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	In line with Health and Disability Services Standards (HDSS) and infection prevention and control standard, surveillance of infections is occurring as per the HDSS IC surveillance guide, and is the responsibility of the ICN.  Daily incidents of infections and the required management plan are presented at handover ensuring early interventions. Surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions. Surveillance data is fed into the company's centralised data collection site for overall comparison, analysis and benchmarking.  Incidents of infections are presented at the quality, RN and health and safety meetings, with any ongoing corrective actions discussed and presented to staff at staff meetings, as evidenced by meeting records, infection control records and staff interviews. There have been no recent outbreaks of infections.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The organisation has a comprehensive suite of policies and procedures which meet the requirements of the restraint minimisation and safe practice standards. The restraint coordinator is on parental leave and the clinical services manager, who provides support and oversight to the restraint management processes of the facility, was interviewed. He demonstrated a sound understanding of Ultimate Care's policies and procedures and these clearly guide practice.

		<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 clinical services manager and on review of restraint approval group minutes and file records of those residents who have approved restraints. The use of restraints is minimised as much as possible while maintaining safety.</p> <p>On the days of audit there were two residents using enablers. In both cases the residents have requested the equipment in use 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 resident. In both cases the resident is voluntarily using the equipment and it is included in their care plan.</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>There is a restraint approval process and a restraint approval group. The group is made up of a range of care staff from both nursing and care giving staff, and across all shifts. The approval group meets regularly every two months.</p> <p>Restraints are used for safety only. Records were reviewed and confirmed that the restraint coordinator, in consultation with the clinical services manager, have accountability and responsibility for restraint processes at Rhapsody. The organisation's processes are implemented and the approval process is followed.</p> <p>On the days of audit there were four residents with approved restraints. It is evident from review of restraint approval group meeting minutes and collated data, that the overall use of restraints has reduced in the last year partly due to the clinical manager's leadership.</p> <p>There is a position description for the restraint coordinator which describes the role and responsibilities. The meeting minutes and records on resident files demonstrate that the restraint coordinator has been undertaking the role as described.</p> <p>Residents who have approved restraints have all 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>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	FA	<p>The assessment process includes all requirements of this standard. The initial assessment is undertaken by the restraint coordinator or another registered nurse with the restraint coordinator's involvement, and input from the resident's family/whanau/EPOA. The general practitioner is always</p>

<p>undertaken, where indicated, in relation to use of restraint.</p>		<p>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, whomever is most appropriate. All four residents using restraints at the time of the audit have a current assessment and consent form.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised. At interview with the clinical services manager he 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 implemented.</p> <p>Restraint approval group meeting minutes record these discussions. Family/whanau interviewed confirm 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 restraint approval group meeting. The register for the past eight months was reviewed with the clinical services manager (this is the time he has been at Rhapsody). The register has been maintained throughout this time. Changes on the register reflect changes in need and resident changes over this time.</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.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint approval group evaluates the use of restraints for every resident at least every six months. This includes a review and updating all the documentation relating the use of the restraint, (ie, the assessment, consent, monitoring) and feedback is sought 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. The timeframe for monitoring is included in the resident's care plan and monitoring forms record that this occurs as described in residents' plans.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The clinical services manager and restraint approval group 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 facilities and externally since the end of 2015 (see standard 1.2.3).</p> <p>The restraint monitoring and quality review documentation has occurred regularly since January 2015. The trend is for decline in the use of restraints (as noted), and an increase in staff training, both in completion of the core training and additional training provided in the annual calendar.</p> <p>An interview with a resident and their family member confirmed consultation and involvement in decision making, with an emphasis on minimisation and utilising alternatives to restraints wherever possible. Interviews with staff members confirmed their understanding of a focus on safety, wellbeing and reducing the use of restraints as much as practicable.</p>

## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Residents requested they would like to start a worm farm, based on their experiences of having worm farms in the past, and its benefits for their gardens. They were assisted to set it up and manage the ongoing needs of the worms, including the bottling of the urine. Families assist in providing residents with the ongoing food to feed the worms, bottles for bottling the worm urine and selling of the product. The residents held a competition to design the label for the bottles. The local paper was involved in promoting the product. A review by the residents identified a shortage in meeting demand; the facility now works in conjunction with the local kindergarten and their worm farm to meet ongoing demands.</p> <p>Residents decided they wanted to hold a fair. Planning included identifying products and stalls to be included in the fair. Residents and families made, purchased and collected items to make to be sold at the fair. Regular excursions to the local hospice shop provided access to items residents could put to good use. The local community was given opportunity to participate in the fair. Residents managed the stalls. A review by residents has identified the fair was a big success and opportunities for improvement</p>	<p>Three quality initiatives were identified and implemented in response to an expressed interest by residents at a residents meeting. The initiatives included the involvement of residents in the planning, monitoring and review of these activities. A formal review of each initiative has identified residents' increased pleasure, a sense of achievement, improved social interaction and improved satisfaction.</p>

		<p>in planning for the next fair are being addressed.</p> <p>Residents requested an 'Americana day', and identified what needed to happen for the theme to be Americana. The building was decorated, banners, balloons and American car owners contacted for their participation. Residents and families were driven around in American cars. All residents expressed positive feedback to their achievements in regards to the success of the day.</p>	
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End of the report.