

# Rangiura Trust Board

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## Introduction

This report records the results of a Surveillance 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 Health Audit (NZ) 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>	Rangiura Trust Board
<b>Premises audited:</b>	Rangiura Rest Home & Retirement Village
<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: 7 December 2016      End date: 8 December 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>	76

# 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

Rangiura Trust Board provides rest home, hospital level and secure dementia level of care for up to 81 residents. There were 76 residents at the time of audit. The strengths of the organisation is their ongoing implementation of the Eden Alternative approach to service delivery.

This unannounced (spot) audit was conducted against the relevant Health and Disability Services Standards and the service's contract with the district health board. The audit process included an onsite audit and sample of resident and staff records, observations and interviews. Interviews were conducted with residents, families, management, clinical and non-clinical staff and a general practitioner.

This audit has resulted in a continuous improvement rating in governance and education. No systemic issues or shortfalls were identified.

## 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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The organisation has effective communication strategies in place, this includes access to interpreters as required and strategies for communicating with residents with cognitive impairment. There is open communication that is reflective of the organisation's open disclosure policy.

There is an easy to access complaints management system. When complaints and feedback have been received, they are managed in time frames that are consistent with legislative requirements. The complaints log records all complaints, dates and actions taken.

## 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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A business plan and quality and risk management plan is documented and includes the mission and goals of the service. The organisational mission, vision and philosophy are incorporated into the Eden Alternative approach to person centred service delivery. The Eden Alternative philosophy is aimed at addressing 'loneliness, helplessness and boredom' through organisational culture change. There is a process in place for the regular reporting against these goals.

The organisation is managed by an experienced and suitably qualified general manager, who is supported by a clinical team. The organisation is governed by a board of trustees. The service is also part of a wider community trust board along with other smaller rural providers across the Waikato.

Quality management data is collected, analysed and evaluated, with actions implemented to address any shortfalls identified. There is an internal audit programme that covers all aspects of service delivery. Adverse events are documented and there is evidence of improvements implemented based on the findings.

There are policies on human resource management. Practising certificates are current for all staff that require them. Staff records have the required information, including staff education records. Staff report access to in-service and external training. The Eden

Alternative and other education programmes are conducted to make improvements to service delivery. An orientation programme is in place and completed for new employees. The staff have appropriate qualifications to provide services and supports to the residents living in the dementia unit.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. Care staff reported there are adequate staff available.

## 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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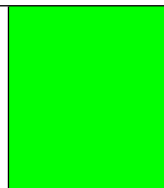
Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Long and short term care plans are developed and evaluated in a timely manner. Interventions are sufficiently detailed to address the desired goals/outcomes. Short term care plans are developed when acute conditions are identified and resolutions are documented. A 24-hour activity is in place to manage residents in the dementia unit. Planned activities are appropriate to the needs, age and culture of the residents who reported that the activities provided are enjoyable and meaningful to them.

The medicine management system meets the required regulations and guidelines.

Food services meet the food safety guidelines and legislation. The individual food, fluids and nutritional needs of the residents are met. Resident records sampled confirmed that stable weights and interventions are in place when weight changes are identified.

## Safe and appropriate environment

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

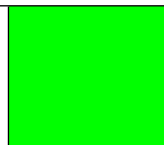


Standards applicable to this service fully attained.

There is a current building warrant of fitness. There have not been any changes to the layout of the building, since the last provisional audit, that has required changes to the evacuation scheme.

## 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.

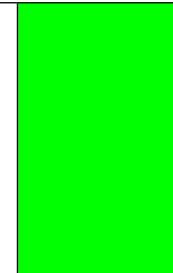


Standards applicable to this service fully attained.

Policies and procedures identify the safe use of restraints and enablers which are utilised as the least restrictive option that allows the residents to maintain independence, comfort and safety. Risk management plans are in place to prevent restraint-related injuries.

## 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.

Infection prevention and control policies and procedures are in place to maintain a low infection rate in the facility. The infection control coordinator collates and analyses the monthly infection control data. The type of surveillance is appropriate to the size and complexity of the service. The infection rate data is reported to the board and benchmarked with other facilities.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	17	0	0	0	0	0
<b>Criteria</b>	2	38	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints process and policy comply with Right 10 of the Code. There is a complaints log that contains all complaints, dates and actions taken. There have been no complaints related to the aged care service. Management and staff report understanding of the complaints handling process. Residents and families reported that they would make a complaint if they needed to do so. Complaints processes are explained to residents and families on admission to the organisation and reinforced at resident meetings. Complaints forms are available throughout the building.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and families receive communication that reflects the organisation's open disclosure policy. Incident and accident forms sampled record that the residents, and where appropriate, family are notified of any adverse events. Resident's files sampled provided guidelines on how to effectively communicate with residents, including strategies for communication with residents who are non-verbal or with cognitive impairment. All residents are able to understand English. There are processes documented on how to access interpreting services if required to meet the resident's needs. The organisation has a number of multi-lingual staff.</p>

<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>	<p>FA</p>	<p>Services are planned to meet the individual needs of the residents at the different levels of care. The service has a separated secure specialist dementia unit (Fern Haven House) that can cater for up to 19 residents as three of the rooms can be used as double rooms for couples. There is one rest home only wing of eight beds and the remainder of the rooms in the rest home/hospital building being dual purpose (either rest home or hospital level of care). At the time of audit there were 16 residents living in the specialist secure dementia unit, 20 hospital level of care residents (including two younger people under the age of 65) and 40 residents at rest home level of care.</p> <p>There is a business and strategic plan that clearly identifies the mission, values and philosophy of the organisation. One of the key aspects of the organisation is their commitment to full registration and recognition of the Eden Alternative to service delivery. There is a board of trustees and within the board and management structure there is an executive committee, which includes the general manager (GM). The way that the service has implemented their purpose, values, scope, direction, and goals has gained a continuous improvement rating.</p> <p>In addition to the management team, there is an executive subcommittee of the Board and a full board. Facility management report to, and work closely with, the executive committee. The executive committee meet a least monthly, with a full Board meeting occurring bi-monthly. Interviews with one of the Board members and member of the executive committee reports that the service is focused on the implementation of the Eden philosophy.</p> <p>The chair of the board is also on the Eden Alternative Board in New Zealand. The goals of the strategic plan are reviewed at the bimonthly board meetings. The board chair has a formal meeting with the GM at least weekly to discuss and monitor organisational performance and progress in meeting the organisational goals. There are also informal meetings during the week, as the chair of the board is onsite at least 10 hours' per week. The GM reports to, and work closely with, the executive committee.</p> <p>The organisation is also part of a wider community trust board for shared vision and representation for smaller aged care services in the Waikato region. There is a board member from Rangiora also on the wider trust board.</p> <p>The organisation is managed by a GM who has a background as a psychiatric nurse and management of disability services. The GM has managed this service for two years. The GM is supported by a clinical nurse administrator and a clinical nurse leader, who are both registered nurses (RNs). The sighted job descriptions for the GM identifies their roles and responsibilities. The chair of the board reports confidence in the GM to manage the service.</p> <p>The residents and families report satisfaction with the services and supports provided at Rangiora.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>The quality and risk management plan was last updated and reviewed in 2016. Each of the quality goals incorporates processes of effectiveness, safety, responsiveness and accessibility fundamental to health and</p>

<p><b>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>disability service provision. There are goals and objectives for all aspects of service delivery, incorporating the Eden Alternative philosophy and approach. Staff meetings and staff bulletins provide a forum for discussing and communicating quality and risk issues to the wider team. Staff interviewed demonstrated knowledge of the quality and risk management systems.</p> <p>Policies and procedures are developed by an aged care consultant, and personalised to the organisation. Policies are reviewed in a two-year cycle, or sooner if there are any best practice or legislative changes. The manager receives updates from an aged care consultant as policies are updated. Staff only have access to the most recent version of policies and procedures. The obsolete documents are archived. There is system in place to enable the retrieval of documents as needed. Archiving and destruction of records is conducted in line with legislation.</p> <p>The internal auditing system (including safety inspection, satisfaction surveys and Eden self-assessments) is used to monitor the quality and risk management system. The internal audit schedule covers all aspects of service delivery. Internal audits sampled record the aim, method, frequency, audit outcomes, comments and recommendations. If shortfalls are identified, a corrective action/quality improvement plan is commenced. Corrective action plans sighted record the area for improvement, the improvement plan, who is responsible, time frames for implementation and measurable improvement indicators to review if actions have been effective and if a re-audit is required. Feedback from the improvements is shared with staff at the staff meetings.</p> <p>Quality results and data are reviewed and evaluated through staff, management and governance meetings. The health and safety community reviews data related to falls, hazards, infection control and the environment. Quality data is benchmarked monthly with other aged care services.</p> <p>The business plan includes risk analysis. This records organisational risks, actions implemented and monitoring requirements to reduce/minimise the occurrence or impact of the risk. The hazard register records actual and potential hazards in the care services, cleaning and laundry, external environment and kitchen. The register records the actions implemented to eliminate or minimise the hazards. The register records the severity of the risk and the frequency of monitoring. Staff demonstrated knowledge of the reporting of new hazards and the actions that are implemented to reduce actual and potential hazards.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected</p>	<p>FA</p>	<p>In interview, management team members understood their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified as identified in policy. This includes obligations to report stage three and above pressure injuries.</p> <p>Staff demonstrated a knowledge of when to complete an accident/incident form. The monthly collation of adverse events is used to identify any shortfalls and record actions that have been taken to address any issues. The individual events and the trend data is used to make improvements to service delivery. Process of implementation of post falls strategies are sighted in the resident files sampled.</p>

<p>consumers and where appropriate their family/whānau of choice in an open manner.</p>		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>All staff and contractors who require a practicing certificate have these verified annually. Current practicing certificates were sighted for all staff who require them.</p> <p>There are policies and procedures on human resource management. The skills and knowledge required for each position is documented in job descriptions which were evident on each personal record sampled. Records of the pre-employment process confirmed interview, reference checking and police vetting.</p> <p>The orientation process covers all essential components of the services provided and the Eden Alternative philosophy. There are also specific orientation training and competencies for the different roles. There is a specific orientation to the dementia unit, that covers the specialist environment, behaviour management, meaningful activities and person centred approach. Staff members interviewed found the information provided to be informative and supportive. Staff annual performance appraisals were sighted in the staff files sampled.</p> <p>The education plan meets contractual requirements. Education attendance sheets are maintained. The service has links with another aged care service for ongoing education and competency assessment training. The 2016 programme was reviewed and evidenced that education is provided as part of in-service education and access to external providers. Individual records of education are maintained for each staff member and were sampled. All relevant staff have medication competencies. There are adequate numbers of registered nurses (RNs) who are trained in the interRAI assessment programme (with one more RN booked for interRAI training when this is next available). Staff interviewed reported that they have sufficient access to education. In addition to the standard ongoing education programme, there are specific education projects aimed at improving service delivery.</p> <p>All caregivers and domestic staff who work in the dementia unit have either completed or are in the process of completing (two staff who have been at the service for less than six months) the required national dementia unit standards. The diversional therapy/activities coordinators who work in the dementia unit have specific training related to dementia care.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p>	<p>FA</p>	<p>There is a documented allocation of staff to meet the needs of the residents at rest home, hospital and dementia level of care. The policy meets the contractual requirements for the care staff ratio. Staff interviewed reported that there were adequate staff available and that they were able to complete the work allocated to them. There is at least one RN on duty at all times, with up to four RN's on during the morning shift. The dementia unit has an allocated RN shift seven days a week. There are at least two care staff members on duty at the busiest times of the day. At other times there is at least six care staff members on duty at night, with another staff member on</p>

<p>qualified/skilled and/or experienced service providers.</p>		<p>call. There are two staff rostered in the dementia unit for all shifts (including night shift). Rosters confirm leave is replaced.</p> <p>In addition to the care staff, there are sufficient numbers of cooking, cleaning, laundry, physiotherapy, activities/diversional therapy and maintenance staff to meet the needs of the residents and ongoing running of the service. The organisation also has a number of volunteers to assist with resident activities and socialising. Residents and family member interviewed reported that there is enough staff to provide their relative with adequate care. Observations during the audit confirmed adequate staff cover is provided.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>A medicine management system is implemented to ensure safe delivery of medicines to the residents. Allergies are documented and indications as well as crushing instructions of medicines are documented. Medication records are reviewed every three months. Weekly and six monthly controlled drugs stocktakes are conducted. The controlled drugs register is correct and current. The medicine fridge is monitored and the temperature is recorded daily. A system is in place when returning expired or unwanted medications to the pharmacy. All medications are stored appropriately.</p> <p>The staff administering the lunchtime medications complied with the medicine administration policies and procedures. Current medication competencies are evidenced in the staff files.</p> <p>There are no residents who self-administer medications. Policies and procedures are in place to ensure safe storage and compliance in relation to self-administration of medications.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food service policies and procedures include principle of food safety, ordering, storage, cooking, reheating and food handling. A system is in place when receiving and utilising supplies. Staff who work in the kitchen have current food handling certificates. The kitchen staff use safe food handling practices when preparing meals. A kitchen cleaning schedule is in place. Residents living in the dementia unit have access to food and snacks 24 hours a day.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. Dietary requirement forms are completed by RNs on admission and a copy is provided to the kitchen. Modified foods are provided by the service. The meals are well-presented and the residents confirmed that they are provided with an alternative meal as per request. Residents have stable weights and residents with weight changes are provide with food supplements or fortified foods.</p> <p>All meals are prepared and cooked onsite. Cooked meals are plated from the kitchen to the main dining area while meals for the residents in the other units are plated and reheated before serving. Fridge temperatures are recorded weekly and food temperatures are recorded daily. There is evidence that the current menu is reviewed</p>

		every two years by a dietitian.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Long and short term care plans are developed by the RNs. Interventions in both long and short term care plans are sufficiently detailed to address the desired goals/outcomes. Documented interventions are practical and staff reported that it is easy to follow and realistic. The interventions are reflective of the originations person centred Eden Alternative approach. The service delivery in the specific dementia unit are flexible to meet the needs of the residents with cognitive impairment. The residents and families reported high satisfaction with the service delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Activities provided are appropriate to the needs, age and culture of the residents. The residents and relatives report that the activities are developed to be physically and mentally stimulating. The diversional therapist (DT) develops the activity plans using the resident's profile gathered during the interview with the resident and their families. There are two activity assistants working with the DT who are on-training to become a DT. The activity assistant working in the dementia unit has completed a dementia paper.</p> <p>Weekly activities are posted in the dining areas, notice boards and activity lounge. Activity plans are well-documented and reflect the resident's preferred activities. A 24-hour activity plan is in place for residents in the dementia unit. A participation log is maintained. Residents are referred to the RNs or physiotherapist when involvement in activities changes. Interviewed residents and their families reported satisfaction with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long and short term care plans are evaluated in a comprehensive and timely manner. Evaluations include the resident's degree of achievement towards meeting the desired goals/outcomes. Resident's response to the treatment regime in the short term care plan is documented. Changes in the interventions in both long and short term care plans are initiated when the desired goals/outcomes are not satisfactory. Residents and relatives report satisfaction with the provision of care, support and service delivery.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided</p>	FA	<p>There is a current building warrant of fitness displayed. There have been no changes to the layout of the building that require the remainder of the standard to be audited at this surveillance audit.</p>

with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	There have been no changes to the layout of the building that require this standard to be audited at this surveillance audit. The trail evacuation drill has been conducted within the last six months.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	Surveillance activities are appropriate to the size and complexity of the setting. Surveillance is carried out in accordance to the agreed objectives and methods in the infection control programme. The clinical nurse administrator (CAN) is the designated infection control coordinator. Infection rates data are monitored and analysed by the infection control coordinator. Interventions to reduce infections are discussed in the monthly staff meetings and during handovers. Monthly infection data are reported to the board and benchmarked with other providers.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The service demonstrated that the use of restraint is utilised as a last resort in providing safety and comfort to the residents. There are 15 residents using restraints and four residents using an enabler. There is no restraint use in the dementia unit, with the environment designed for residents with cognitive impairment to wander freely in a secure environment. The restraint register is current and updated. Risk management plans are in place to minimise restraint-related injuries. The policies and procedures are in place with definitions of restraints and enablers. Staff demonstrated good knowledge regarding restraints and enablers. The physiotherapist is the designated restraint coordinator for the service.

## Specific results for criterion where corrective actions are required

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

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

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

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>The ongoing implementation of the Eden Alternative approach at all levels of the organisation is commended. The chair of the Rangiura Board is also on the ‘Eden in Oz &amp; NZ’ volunteer board of governance. The service has gained recognition, both nationally and internationally for the Fern Haven Houses (specialist dementia unit) that was designed and built with the Eden Alternatives’ ‘Greenhouse Memory Support Home’ The service has conducted a number of ongoing quality improvement projects in gaining formal recognition for principle seven of the Eden Alternative. The projects include a self-assessment from the board and other staff members, and progress reports which involve a review process which includes analysis and reporting of findings of how the organisation is progressing towards gaining ongoing Eden registration. The evaluation of these projects evidences positive results in residents’ safety and satisfaction.</p>	<p>The organisation’s implementation of Eden Alternative philosophy into the values, scope, direction and goals of the organisation is rated beyond the full attainment. As part of the integration of the Eden philosophy and projects in gaining recognition of further Eden principles since the last certification audit including an analysis of how the organisation is implementing the Eden philosophy, which includes a self -assessment, Eden community visitors and reporting externally to the Eden Alternative organisation. These reports show the range of benefits derived from the implementing of the Eden Alternative philosophy. The</p>

			implementation of the Eden Alternative is providing positive outcomes in resident and family satisfaction in the quality of the care provided.
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>The organisation continues to meet the continuous improvement rating for the ongoing education programme. Since the last certification audit the organisation has implemented a number of targeted education projects to make further improvements to service delivery. These include education for staff, volunteers and residents/families on principle seven of the Eden Alternative, 'Medical treatment should be the servant of genuine human caring, never its master'. All staff have completed training related to this, with specifically trained Eden associates conducting projects (dementia beyond drugs) related to reducing medications for behaviour management for residents living in the dementia unit. Another education project was conducted in 2016 related to workplace communication. Both these education projects have documented programme, progress reports, reporting and analysing of findings and improvements. Feedback from learners and management is included in the reporting, of how the education project have make improvements to practice. The residents and family's feedback is gained through satisfaction surveys, which includes a narrative of positive improvements that have occurred. The projects have resulted in positive communicating outcomes, reduction in complaints and issues related to poor communication and improved completion of documentation.</p>	<p>The system to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to residents is rated beyond the full attainment. The ongoing education that is provided exceeds the requirements set out by the district health board. An analysis of the education and professional development occurs through the operational reports. These reports show the range and investment in staff education and ongoing training that has been implemented. The implementation of the ongoing education programme is providing positive outcomes in resident and family satisfaction in the quality of the care provided.</p>

End of the report.