

Heritage Lifecare Limited - Carter House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Heritage Lifecare Limited

Premises audited: Carter House

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 23 August 2016 End date: 24 August 2016

Proposed changes to current services (if any): Heritage Lifecare Limited are in negotiations on the purchase of this facility and hope to go unconditional on the 8 September 2016.

Total beds occupied across all premises included in the audit on the first day of the audit: 64



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

General overview of the audit

Carter House provides rest home, dementia and hospital level care for up to 65 residents. The service is operated by Anglican Care Waiapu and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the Bay of Plenty district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, and a general practitioner. The prospective owner's representative was present and was interviewed during the audit process.

The service has a positive atmosphere which was commented on by staff, residents, family members and the GP. A strength of the organisation is the work carried out by the health and safety co-ordinator. Three areas requiring improvements were identified at audit; two relating to care planning and one related to the environment.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Resident who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has strong linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

Anglican Care Waiapu is the governing body and is responsible for the service provided at this facility. Anglican Care Waiapu have a strategic plan that includes the vision, purpose, mission statement, core values and passion of the organisation, this is used in the development of a facility specific business plan.

The facility is managed by an experienced and suitably qualified manager, supported by a clinical manager who is a registered nurse.

There is an organisation wide quality and risk management plan and systems are in place for monitoring the services provided, including regular monthly reporting by the facility manager through to the governing body. Quality and risk includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where necessary. Reporting occurs to the organisation's clinical quality and compliance manager, who undertakes benchmarking among the organisation's facilities. Meeting minutes, graphs of clinical indicators and benchmarking results are displayed.

Adverse events are documented on incident forms. Corrective action plans are being developed and implemented where required. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks and hazards are identified, mitigated and are up to date.

A suite of organisation wide policies and procedures cover the necessary areas, with some facility specific policies in place. Regular reviews occur and presently some policies are under review and out for discussion.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. An orientation and staff training programme ensures staff are competent to undertake their role. An annual training plan is in place and a record of ongoing training is in staff files. Regular individual performance review are undertaken.

Staffing levels and skill mix meet contractual requirements and the needs of residents. Senior staff are on call after hours and at weekends.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained.

The prospective owner has a transitional plans which does not include changing the present management structure. Heritage Lifecare Limited will review the present quality and risk plan and process, policies and procedures and may merge some into their present documentation in the future.

Continuum of service delivery

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff (eg, pharmacist, podiatrist) and the residents' general practitioner. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Health variation plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

Safe and appropriate environment

The facility has been purpose built. All rooms are single, some with ensuite shared toilet facilities between two residents. All are of adequate size to provide personal care.

All building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative maintenance plan is in place and reactive maintenance occurs.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite, with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to an emergency power source is available. Residents report a timely staff response to call bells. A contracted security company monitors the facility each night.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Four enablers and nine restraints are in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and ongoing, including all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated knowledge and understanding of the restraint and enabler processes

Infection prevention and control

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is able to be accessed from an external advisor. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken with data analysed, trended, and benchmarked, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	46	0	1	2	0	0
Criteria	1	97	0	1	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Carter House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed, understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, agreement to collect information and consent for disclosure of information to other health providers.</p> <p>Advance care planning, establishing and documenting enduring power</p>

		<p>of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident's records. EPOAs are sighted in the files of residents in the secure unit, or where an EPOA is not in place interview and documentation verifies the facility manager is supporting actions to have one appointed. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff are aware of how to access the Advocacy Service and verify examples of their involvement with the service, at staff and resident meetings.</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 and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The Anglican Care Waiapu has an organisation wide complaints policy with associated forms that meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information available at reception. Complaints are discussed at residents' meetings where appropriate. This was</p>

		<p>confirmed by the facility manager, the minutes of residents' meetings and at interview with family members.</p> <p>The complaints register reviewed with the facility manager and the clinical quality and compliance manager showed that eight complaints have been received over the past year. It includes documentation of actions taken, through to an agreed resolution these are sighted as being completed within the timeframes specified in the Code. Action plans reviewed show any required follow up and improvements have been made where possible. One Health and Disability Commissioners complaint occurred in the last year and has been closed by the Commissioner's office.</p> <p>The facility manager confirmed they are responsible for complaints management and follow up. All staff interviewed confirmed they have received training, demonstrated a understanding of the complaint process and what actions are required should someone wish to lodge a complaint or give feedback.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Heritage Lifecare Limited (the prospective owner) own and provide management services to a number of rest home facilities and the quality and compliance manager spoken with during audit confirmed that they have a sound knowledge of the Code.</p> <p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through part of the admission information provided, pamphlets and posters located around the facility and discussion with the clinical manager. The Code is displayed in a range of areas together with information on advocacy services, how to make a complaint and feedback forms.</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</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed</p>

<p>independence.</p>		<p>doing so throughout the audit (eg, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and when responding to resident's request for assistance). All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by assistance being provided to remain as independent as possible, to participate in community activities, to be offered choice in as many opportunities as possible and to be an active participant in decision making. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff interviews and training records.</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>Staff support the two residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. A family member of a resident who identifies with the Maori culture reported by interview that staff acknowledged and respected the cultural needs of their family member by acknowledging and complying with practices that were important.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>all care plans reviewed (eg, nutritional and spiritual requirements). A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a code of conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, physiotherapist, community dieticians, services for older people, psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included all care staff working in the facility being trained in caring for residents with dementia, introduction of assessment and classification tools to</p>

		guide practice and the use of graphs to monitor medication effectiveness. Documentation, observation and interviews verify the value of the introduction of these tools to clinical practice and resident care.
<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 family members stated they were kept well informed about any changes to their/their relative's status. They were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews and this was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are known and able to be accessed when required. Staff knew how to do so, although reported this was rarely required due to most residents being able to speak English.</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>	FA	<p>Anglican Care Waiapu, Board of Directors have developed a strategic plan that outline the purpose, values, scope, direction and goals of the organisation and is signed off by the Anglican Bishop. This is used by each facility to develop a business plans, which is signed off by the regional operations manager. These documents are reviewed annually and describe annual and longer term objectives and the associated operational plans. The facility manager receives reports from her senior staff which informs the monthly report to the regional operations manager. These reports are templated and provides evidence against the objectives and key performance indicators. The clinical quality compliance manager stated this information then goes to the Board, this was confirmed by the regional operations manager. A sample of reports reviewed shows adequate information to monitor performance is reported including, quality and risk, financial, complaints, health and safety.</p> <p>The service is managed by a facility manager who is an enrolled nurse (who does not have a current annual practising certificate) and she</p>

		<p>holds relevant qualifications in business management, she has been in the role for five years. She is suitably experienced for the role and has responsibilities and accountabilities are defined in a job description, individual employment agreement and delegated authorities policy. The facility manger and clinical quality compliance manager were able to confirm knowledge of the sector, regulatory and reporting requirements and maintains currency through attending conferences and updates from the Ministry and New Zealand Aged Care Association. The facility manager is supported by the clinical manager and quality coordinator who are registered nurses, they meet on day to day basis and provide reports to the facility manager monthly.</p> <p>The service holds contracts with Bay of Plenty DHB for, rest home, hospital and dementia beds. Sixty five residents receive services under these contracts, on the day of audit there were, 18 rest home, 17 dementia and 29 hospital beds occupied.</p> <p>The prospective owner's (HLL) provide aged related services and management services to other service providers presently and have a working knowledge of the contracts the present owner has with the district health board. The clinical quality and compliance manager provided evidence of planning for the transition and stated that the structure within the facility would remain unchanged, including registered nurse full time equivalents. The Bay of Plenty DHB and the Ministry are aware of the plan to purchase this service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the facility manager is absent, the clinical nurse manager carries out all the required duties under delegated authority. They are supported by the clinical quality and compliance manager and the regional operations manager. During absences of the clinical nurse manager the quality manager would oversee the facility. They are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>The prospective owners will continue with the present management structure and arrangements including contingencies when senior staff are not available.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a quality and risk system that is overseen by the Anglican Care Waiapu clinical quality and compliance manager and delegated at each facility to the quality coordinator. This reflects the principles of continuous improvement and is understood by the staff spoken with. This includes the management of incidents and complaints, annual audit activities, a regular family satisfaction survey, monitoring of outcomes, clinical incidents including restraint, infections, falls and skin tears.</p> <p>There is a quality and risk, infection control, health and safety meeting, monthly and a separate falls committee meeting. The minutes of these meetings confirmed adequate reporting systems and discussion occurs on quality matters including pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results and activities. Organisational quality coordinator meetings occur quarterly to allow for education and discussion on quality issues. Monthly reports go to the clinical quality and compliance manager and the facility manager, this includes results of audits and where they do not meet the target, corrective actions plans are required and reviewed by the clinical quality and compliance manager and this allows for analysis and trending of quality indicators to occur.</p> <p>Benchmarking occurs between the facilities and the clinical quality and compliance manager is looking into external benchmarking with similar organisations. There was evidence of corrective actions being undertaken and carried forward to the next meeting for follow through. Minutes of staff meetings showed that staff are informed of quality issues and this was confirmed by staff spoken with. Resident meetings and family surveys are completed annually. The last survey showed overall satisfaction with the service provided and narrative comments being actioned where necessary.</p> <p>Policy development, review and document control is undertaken by the clinical quality and compliance manager and cover all necessary aspects of the service and contractual requirements. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents by delegated staff member at each facility. A few</p>

		<p>policies were identified as being past their review date and the clinical quality and compliance manager was able to provide evidence that these are under review and out for discussion, this included health and safety and restraint minimization. Staff are updated on new policies or changes to policies through Time Target (staff electronic time in and out system), notices and at staff meetings. This was confirmed by staff spoken with and minutes of staff meetings.</p> <p>The clinical quality and compliance manager and facility manager provided evidence via the organisational strategic plan of the identification and mitigation of strategic risks. These are reviewed annually as part of the review of the document. The maintenance person/gardener is the health and safety officer and has undertaken training relevant to the position including in the Health and Safety at Work Act (2015). They are able to describe the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register shows consistent review and updating of risks and the addition of new risks. They were able to describe actions taken to reduce risks to staff and residents. The facility was assessed by Accident Compensation Corporation (ACC) Partnership Programme as meeting tertiary level compliance.</p> <p>Heritage Lifecare Limited have a corporate quality and risk management plan which includes an audit schedule, clinical indicators and policies and procedures that meet the requirements of the standard and contract requirements. They plan to look at the current Anglican Care Waiapu plans and work towards a combination of both processes.</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>CI</p>	<p>Staff document adverse and near miss events on an incident form. This was confirmed by staff during interview. There are processes in place to ensure incidents are managed promptly and reported to senior staff where required promptly. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is sent to the most appropriate staff member for management, example hazards to the health and safety co-ordinator. Collation, analyses, including by type and resident and reported via</p>

		<p>reports to the clinical quality and compliance manager and the facility manager. Minutes of the quality and risk, infection control and health and safety meeting reviewed show discussion in relation to trends, action plans and improvements made.</p> <p>The clinical quality and compliance manager, facility manager and health and safety officer are able to described essential notification reporting requirements (eg, pressure injuries, health and safety, human resources, infection control, the coroner, the DHB). The clinical quality and compliance manager is advised of serious events and undertakes the reporting to the Ministry. They advised there have been notifications of significant events made to the Ministry of Health.</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>Policies and procedures reviewed are in line with good employment practice and relevant legislation, and guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. This process was confirmed by the facility manager. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>The quality co-ordinator provided evidence of role specific orientation workbooks that includes all necessary components relevant to legislation, these standards, contract requirements and good practice. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>The clinical quality and compliance manager confirmed that continuing education is planned on an annual basis. The organisational defined mandatory training including the completion of a number of competencies, such as restraint, manual handling, infection control and medication for registered nurses requirements are defined. The quality co-ordinator spoke of facility specific additional training identified and</p>

		<p>added to the annual month by month schedule. All registered nurses have a current first aid certificate and are encouraged to undertake ongoing post graduate training relevant to the service. An example given related to a leadership course. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A number of registered nurses are Careerforce internal assessors for the programme. The organisation policy is to have all caregivers undertake dementia training, as may residents in the other areas have a degree of dementia. This also facilitates staff deployment across the whole facility. Education records reviewed demonstrated completion of the required training. Staff interviewed confirmed continuing requirements to attend training. Appraisals were current for all staff.</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>	<p>FA</p>	<p>There is a documented policy on staffing mix that covers the contract requirements and includes the rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The quality coordinator stated that the facility adjusts staffing levels to meet the changing needs of residents. Two days a week are rostered for registered nurses to complete the interRAI assessments. The minimum number of staff is provided during the night shift and consists of one registered nurse and three caregivers. Afterhours and weekends senior staff are on call; this includes the clinical and the facility manager. Staff report good access to advice is available when needed. The review of the four-week roster cycle sampled over five weeks confirmed adequate staff cover has been provided. The organisation has part time staff and a small casual pool, and they have a contract with a bureau for roster gaps. There is RN coverage in the facility on all shifts and all have current first aid certification.</p> <p>Care staff reported ongoing use of bureau staff, at weekends, which has caused dissatisfaction but that they have been able to complete the work allocated to them. This was discussed with the facility manager who was able to evidence reasons for the recent increase use of bureau staff. The budget for bureau staff has been elevated and is reported as part of the monthly report to the Board. Residents and family interviewed and observation during the audit confirmed that</p>

		<p>staff are providing services required of them.</p> <p>The prospective owner's quality and compliance manager is aware of the contracts the facility has and the staffing requirements within these and stated that the present roster system would remain in place.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the clinical manager (CM). They are also provided with written information about the service and the admission process. The service operates a waiting list for entry. The organisation seeks updates information from NASC and GP's for residents accessing respite care.</p> <p>Specialist referral is confirmed for all residents in the secure unit.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in</p>

		accordance with contractual requirements.
<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 as appropriate. The service uses the facilities documentation to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility evidenced a planned and co-ordinated approach. Family of the resident reported being kept well informed during the transfer of their relative.</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 current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</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.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature</p>

		<p>and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There are two residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are used, are current and comply with guidelines.</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>The food service is provided on site by a qualified chef and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes.</p>

		Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident's placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and mental assessment tools, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of the five trained interRAI assessors on site.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress notes, activities notes and medical and allied health professional's notations which are all clearly written, informative and relevant, however interviews, evidence and documentation is unable to support this occurs consistently. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.

		Documentation, observations and interviews verify residents' in the secure unit have behaviour management plans. The behaviour assessment identifies the triggers. Staff are able to verbally identify the triggers and the specific management strategies being used for each individual resident, however the care plan documentation is not reflective of this.
<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	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care, with the exception of those identified in criterion 1.3.5.2. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with 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>The activities programme at Carter House is provided by three full time activity co-ordinators, all who are training to be diversional therapists (DTs) and are being mentored by a qualified DT.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as residents needs change and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities programme is discussed at the residents meeting and minutes indicated residents' input is sought and</p>

		<p>responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme very fulfilling.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. At the time of audit this was in the afternoon and early evening each day of the week. This has resulted in residents having activities or events to attend at times when they appear most active. The stimulation level of activities is reduced as the evening gets later, in preparation for being more settled. Interviews, documentation and observation verifies a reduced need for medication, improved appetite and improved sleep patterns.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>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, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of health variations (short term care plans) were consistently reviewed and progress evaluated as clinically indicated (daily, weekly or fortnightly) and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the</p>

<p>to meet consumer choice/needs.</p>		<p>GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. 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 process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as 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>Documented processes for the management of waste and hazardous substances were in place, including segregation of waste, recycling and detailing procedures for blood and bodily fluids management and disposal.</p> <p>Chemicals are seen stored in locked areas around the organisation with the bulk being in an outside garage. The 'handy man' undertakes the dilution of chemicals where required and has undertaken training in chemical management. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. This was sighted in a sample files of staff involved with cleaning and laundry. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur and state they would report any related incidents in a timely manner.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this, including gloves, masks, face shields and plastic aprons.</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>PA Moderate</p>	<p>A current building warrant of fitness expires November 2016 and is displayed in the reception area. There is a proactive maintenance programme and reactive maintenance is by the use of a diary in each area to log maintenance issues. The testing and tagging of equipment is undertaken by the health and safety coordinator, who has completed appropriate training for this work. The calibration of bio medical equipment is current as confirmed in documentation reviewed,</p>

		<p>interviews with maintenance personnel and observation of the environment.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. The business plan identifies planned facility maintenance for this year, some of which has been carried out. The dementia area has been identified as an area for work with some improvement being undertaken last year to make the area suitable for residents with cognitive deficiency. However, a number of deficiencies were identified at audit and require improvement.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas, including a bowling table and a number of areas for small groups to meet. Efforts are made to ensure the environment is hazard free and that residents are safe. Staff interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned. Residents interviewed and family satisfaction surveys results show that they are happy with the environment.</p> <p>The drying room in the laundry has a fan heater on a timer to come on during the night. There is a cage over the heater and the room has sprinklers installed. The organisation should consider if this heater is required and ensure that nothing is placed on top or above of the cage at any time.</p> <p>The prospective owners have no plans for environmental changes to the facility.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is a mix of toilet, showers and bathing facilities. This includes rooms with ensuites, shared bathrooms between two rooms, communal bathrooms and showers. Toilets are also located near activity areas. An adequate number of accessible bathrooms and toilets are identified throughout the facility. Staff and visitor toilets are available and are separate from residents' toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote</p>

		residents' independence.
<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 rooms are single and were observed to be personalised by each resident and family. Some have their own furnishings, photos and other personal items displayed. Adequate personal space is provided to allow residents and staff to move around within the bedrooms safely including with the use of mobility aids, and the ability to use hoists.</p> <p>There is room to store mobility aids walking frames and wheel chairs. Staff and residents reported the adequacy of bedrooms.</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>A number of communal areas, of varying size, are available for residents to engage in activities or have small group meetings. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. It is arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is undertaken on site in a dedicated laundry, this includes resident's personal items. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently washed by dedicated laundry staff and caregivers on weekends. The processes were observed and were seen to meet good practice. Laundry staff demonstrated that they follow procedures on washing and drying cycles, dirty/clean flow, handling of soiled linen and have been given training on chemical management.</p> <p>There is a small designated cleaning team who has received appropriate training. Chemicals were stored in a lockable cupboard on cleaning trolleys with heavy lids and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and the laundry processes by the chemical company representatives.</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>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The facility manager and health and safety manager spoke of a desk top exercise being undertaken related to a fire evacuation scenario. The current fire evacuation plan was approved by the New Zealand Fire Service in 2008. Trial evacuations takes place six-monthly, the most recent being in July this year. A record is kept of which staff attend to ensure all staff attend one annually. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the number of residents. Water is stored around the facility. There is an agreement with the power company that a generator will be made available if required.</p> <p>Call bells alert staff to residents requiring assistance. The response time can be audited if an issue is identified. Residents and families reported staff respond promptly to call bells.</p> <p>Staff have duress alarms system to seek assistance if required. Appropriate security arrangements are in place. Doors and windows are locked by staff at a predetermined time and a security company checks the premises at night and must report to the registered nurse on duty.</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>	<p>FA</p>	<p>All residents' rooms and communal areas have opening external windows. Heating is provided by hot water radiators which have covers and were observed to be of a temperature that would not burn if touched by residents. The temperature of the facility is monitored and it was confirmed by the facility manager that this was at 20 degrees. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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>	<p>FA</p>	<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 (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from an external IPC advisor. The infection control programme and manual are reviewed annually.</p> <p>The quality co-ordinator/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CM and the organisation's Quality Risk Manager and tabled at the quality/health & safety/IC meeting. This committee includes the facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</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>	<p>FA</p>	<p>The infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role. She has undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with an external IPC advisor, the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The IPC coordinator has access to an online external advisor's 'webinars'. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support</p>

		the programme and any outbreak of an infection.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2015 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the infection control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when a gastrointestinal outbreak occurred in April 2016.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented</p>

		<p>in the electronic resident management system/infection reporting form/clinical record. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, quality meetings and staff meetings. Data is benchmarked internally within the group.</p> <p>Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Anglican Care Waiapu have developed policies and procedures used in their facilities related to restraint minimisation and safe practice; these are currently under review. These meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical nurse manager (CNM) is the restraint coordinator supported by the quality co-ordinator. They provide support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice. There is a restraint coordinator job description which details the role and responsibilities.</p> <p>On the day of audit, nine residents were using restraints and four residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. It was identified via discussions with the quality coordinator and the minutes of the restraint group that enablers were voluntary and used to maintain residents'</p>

		<p>independence and safety.</p> <p>Restraint is used as a last resort when all alternatives have been explored and use ceased when review identifies it is no longer required. This was evident on review of the restraint approval group minutes and files reviewed of those residents who have approved restraints and from interview with the quality co-ordinator. Staff confirmed that education occurs at orientation and is ongoing.</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>	<p>FA</p>	<p>The restraint approval group, terms of reference state the group will be made up of the CNM, quality manager, registered nurses, physiotherapist and diversional therapist, and may include a GP. The quality co-ordinator and minutes confirmed the attendees and that the GP rarely attends A number of incidents related to health and safety have shown corrective actions being taken to eliminate risks to staff and residents. These include:</p> <ol style="list-style-type: none"> 1. An incident occurred where a staff member burnt her hand on the ZIP. Investigation by the health and safety officer showed that the staff member had not followed policy, they were rushing and that there was a need for a more heat resistant glove to be used during this process. Staff were retrained on the process with emphasis on following policy, to take their time, and heat resistant gloves were purchased. An audit was undertaken following these actions and showed staff were following process, using gloves and no further incidents had occurred. 2. The number of falls in the dementia unit were identified as being significantly higher than other areas. The investigation that took place included a check on foot wear being worn by residents to check for fit and sole wear. The flooring was reviewed and non-slip vinyl put down. The review of the cleaning of the floors identified that the cleaners were putting up appropriate alert for wet floors, however, this was agreed as being of little use for these residents. A new process was implemented to include the floor being dried immediately and not left wet. This has resulted in a marked reduction in falls in this area. 3. The staff identified that the residents in the dementia area were eating some of the plants in the area garden. The health and safety officer did research into the plants around the external areas in the

		<p>dementia unit and identified that a number of common plants were poisonous if swallowed. A plan has been put in place and these plants have been removed. but that the GP is involved in the restraint process. The group are responsible for the approval of the use of restraints and the restraint processes, as defined in policy. It was evident from review of restraint approval group meeting minutes, review of residents' files and interview with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family who have Enduring Power of Attorney (EPoA) involvement in the decision making, as is required by the organisation's policies and procedures, was on the restraint consent form in each resident's file where restraint is in use. The lifestyle care plan includes documented restraint and or enabler use and risks associated with the use of these.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint is documented on an assessment form that included all requirements of the Standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator's involvement, and input from the resident's family with EPOA. The use of restraints is actively minimised and the quality coordinator described how alternatives to restraints are discussed with staff and family members. The quality coordinator described the documented process. The GP signs off the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of residents who were using a restraint and all were signed appropriately within a tight timeframe.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Restraint monitoring forms are used to record each episode of restraint use. When restraints are in use, hourly monitoring occurs to ensure the resident cares are being met with recording of toileting, food and drink being given and that the resident remains safe. The monitoring</p>

		<p>form is kept in the resident's file and used by the restraint group for monitoring and to identify if restraint is still required. This was seen completed in three residents' files where restraint is in use. Residents were observed with the use of bed rails in use and it was seen that all processes ensure dignity and privacy being maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and when restraints are deemed necessary to continue or a trial of removal is to be undertaken.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraints is to be minimised and how to maintain safe use was confirmed.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files evidenced the individual use of restraints is reviewed and evaluated monthly by the restraint group, during care plan and interRAI reviews, and six monthly restraint evaluations by the GP. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation includes all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee review all restraint use on a monthly basis, which includes all the requirements of this Standard. Minutes of the restraint group meeting confirmed analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use and the appropriateness of restraint / enabler. Restraint use is reported to the quality meetings and is an item on the staff meeting agenda. Any changes to policies, guidelines, education and processes</p>

		are implemented if indicated. The quality coordinator stated that the use of restraint has been reduced over the last year with a culture shift with registered nurses being more proactive, including completion of the required documentation.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	PA Low	Documentation, observation and interviews verify all residents at Carter House are reviewed and have progress notes written at least once a day by care staff, however not necessarily by a RN. Two of the three files reviewed in the hospital had no documentation by a RN in their progress notes to verify the RN had input into the resident's care each 24 hours. Interviews confirmed not all residents are reviewed daily by the RN.	No documentation is sighted in the progress notes of hospital residents, to verify input by the RN within each 24-hour period.	<p>The RN documents a notation in the progress notes of each hospital resident to evidence RN input at least once every 24 hours.</p> <p>180 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention</p>	PA Moderate	Documentation, interviews and observation verified lifestyle care plans reviewed reflected the residents general support needs,	Lifestyle care plans, do not always describe fully the required support to meet the residents' identified needs following assessment.	Service delivery plans describe fully all required support needed, as identified in the assessment process.

<p>to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>however there were noticeable gaps in five of ten care plans around more complex needs and interventions. Residents with a documented medical condition on assessment had no nursing interventions documented to monitor the resident and manage the condition to ensure the required support was being provided. The care plans of residents in the secure unit were not always reflective of the behaviour management strategies observed and identified in interview. This minimised the opportunity for early detection of potential risks.</p>		<p>90 days</p>
<p>Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Moderate</p>	<p>Maintenance management includes upgrading and repainting of areas within the facility. The dementia unit has had the main corridor and resident's room doors and toilet doors painted in bright individual colours to encourage recognition of these area, there is a colourful mural on one of the walls. One of the rooms has been repainted and upgraded. All other rooms samples were seen to be in need of renovation and there are practices which restrict the use of hot water and residents getting into their wardrobes. The dining area is small for the number of residents and cleaning issues were identified. During environmental observation of</p>	<p>The dining area is of a size that has potential risks for the number of residents being catered for in this area (17). There are cleaning issues observed related to radiators and a curtain in the kitchenette. All rooms visited had the wash hand basin tap heads removed and some had the hot water tap head also removed as well has no wardrobe doors were able to be open by residents as there were kept locked and had no handles.</p>	<p>The dining room in the dementia unit be looked at to ensure residents can move around the tables with ease and staff can access residents in the event of an emergency. The blanket removal of handbasin tap heads and locked wardrobe doors needs to be remove. Residents and staff should have access to hot and cold water in all rooms. The The radiator covers be cleaned frequently, and the kitchen curtain be assessed for purpose and if returned be in good repair and cleaned regularly.</p>

	<p>the dementia unit a number of areas were identified that are in need of improvement:</p> <ol style="list-style-type: none"> 1. The dining area caters for 17 residents, the tables are in close proximity to one another which does not allow residents to easily get into and out of some tables. This is restrictive, for staff to attend to residents in the event of an emergency, and would pose difficulty for residents with walking aids (no resident currently uses an aid). 2. The radiators in this area were observed to have objects inserted into the cover and the covers are dusty. 3. The small kitchenette has a curtain over some low shelves which is torn and need of washing. 4. The hot water tap head has been removed in all rooms visited and some rooms had no tap heads. Staff confirmed this was the common practice. 5. All wardrobe doors have a lock system which requires a key to open them. There is no handle and no means of residents gaining access to their wardrobe. <p>The regional operations manager stated that the dining room issue had been given consideration and a few options had been identified but</p>		90 days
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		were yet to be implemented.		
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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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	CI	<p>The health and safety officer has a dedicated eight hours a week for the role. A current position description outlining their responsibilities is in their personnel file along with evidence of training related to the role, including in the current legislation. At interview it was evident that they have developed systems to ensure a culture of health and safety, including wellness education for staff, and that contractor compliance with requirements is occurring. There is a monthly health and safety award and this was confirmed by staff spoken with. Regular monitoring of compliance is occurring and meeting minutes show hazard identification, mitigation and review.</p> <p>The health and safety officer is able to describe actions taken to reduce risks to staff and residents.</p> <p>A number of incidents related to health and safety</p>	<p>A number of corrective actions sighted showed the elimination of risks to residents. Example being These include actions to reduce the number of falls in the dementia This has resulted in a marked reduction in falls in this area. Also the removal of potentially poisonous plants from the dementia garden where residents walk and assist with gardening and growing their own vegetables.</p>

		<p>have shown corrective actions being taken to eliminate risks to staff and residents. These include:</p> <ol style="list-style-type: none"> 1. An incident occurred where a staff member burnt her hand on the ZIP. Investigation by the health and safety officer showed that the staff member had not followed policy, they were rushing and that there was a need for a more heat resistant glove to be used during this process. Staff were retrained on the process with emphasis on following policy, to take their time, and heat resistant gloves were purchased. An audit was undertaken following these actions and showed staff were following process, using gloves and no further incidents had occurred. 2. The number of falls in the dementia unit were identified as being significantly higher than other areas. The investigation that took place included a check on foot wear being worn by residents to check for fit and sole wear. The flooring was reviewed and non-slip vinyl put down. The review of the cleaning of the floors identified that the cleaners were putting up appropriate alert for wet floors, however, this was agreed as being of little use for these residents. A new process was implemented to include the floor being dried immediately and not left wet. This has resulted in a marked reduction in falls in this area. 3. The staff identified that the residents in the dementia area were eating some of the plants in the area garden. The health and safety officer did research into the plants around the external areas in the dementia unit and identified that a number of common plants were poisonous if swallowed. A plan has been put in place and these plants have been removed. 	
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End of the report.