

CHT Healthcare Trust - Bernadette Life care

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 Health and Disability Auditing New Zealand 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:	CHT Healthcare Trust	
Premises audited:	Bernadette Life Care	
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 25 February 2015	End date: 26 February 2015
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	72	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Bernadette Lifecare provides care to up to 113 rest home and hospital level residents. This provisional audit was conducted to assess the preparedness of a prospective preparedness to provide a health and disability service. The audit included information provided from the potential new area manager, review of the transition plan and interviews with the current facility manager, assistant nurse manager, human resources manager and care staff.

The prospective provider (CHT) have 11 other facilities across the Auckland area. The organisation has comprehensive policies and procedures with which to guide staff. It is CHT's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership which will see the implementation of CHT policies and procedures. The service is currently managed by the nurse manager who has been in the role of nurse manager at the service for nine years. The manager is supported by the assistant nurse manager (registered nurse) and a human resources manager. There are registered nurses on duty at all times. The service continues to provide care to residents based on the current service's mission and philosophy of care. Staff interviewed and documentation reviewed identifies the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

This audit has identified improvements required around aspects of the audit schedule, aspects of human resources, aspects of care planning and medication and aspects of the use of restraint.

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 staff at Bernadette Lifecare ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent and advanced directives are documented. Complaints and concerns have been managed and a complaints register is maintained.

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.		Some standards applicable to this service partially attained and of low risk.
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The new owners of Bernadette Lifecare are experienced providers of aged care services. CHT was formed in 1962 and is a charitable trust. The trust board is supported by a chief executive and a finance manager. The service has a quality and risk management system in place. There is an improvement required round completing of audits as per the audit schedule. The quality programme is monitored and generates improvements in practice and service delivery. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with recent evidence of benchmarking outcome. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented

to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. An improvement is required around staff completing the orientation programme. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Improvements are required around completing individualised care plans, completing nutritional assessments and current pain assessments for those identified with diabetes and pain respectively. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. There is an improvement required around the use of faxed copies of medication charts. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Bernadette Lifecare has a current building warrant of fitness. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are adequate toilet and bathing facilities for residents. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Medical equipment and electrical appliances have been calibrated. There are sufficient communal areas within the facility including lounge and dining areas, including small seating areas and outside sheltered seating. There is a designated laundry and cleaner's room. Hot water temperatures are monitored and recorded. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in a designated external covered area.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were ten residents requiring restraints and seven residents using enablers. The service reviews restraint as part of the quality management and staff are trained in restraint minimisation.

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 control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	5	1	0	0
Criteria	0	94	0	6	1	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>Discussions with staff (four caregivers, three registered nurses, two activities staff, one cook, one facility manager and one assistant manager) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Sixteen residents (nine rest home and seven hospital) and nine relatives (two rest home and seven hospital) we interviewed and confirmed the services being provided are in line with the Code.</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</p>	FA	<p>Informed consent and advanced directives were recorded as evidenced in the 10 resident files reviewed (three rest home, six hospital and one young person with disability). Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed and kept in the administration office.</p>

to make informed choices and give informed consent.		
<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	Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.
<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	Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the facility.
<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	A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained with the registered document reviewed and updated. Systems and processes are in place to ensure that any complaint received is managed and resolved appropriately. Two complaints received in 2015 have been appropriately managed and resolved. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.2: Consumer Rights	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>relatives interviewed identified they are well-informed about the code of rights. Resident meetings and a resident and family survey provide the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and are available at reception.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Church services are held monthly with communion weekly and resident files include cultural and spiritual values (# link 1.3.6.1). Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.</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>The service has a Maori health plan and an individual's values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There is currently one resident at Bernadette Lifecare who identifies as Maori and this is reflected in the residents care plan (# link 1.3.6.1). The service has established links with local Maori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	<p>FA</p>	<p>Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process includes the signing of house rules and a service code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues (# link 1.2.7.3). The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries (# link 1.2.7.4). Registered nursing staff have completed training around professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility (# link 1.2.3.1). Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The facility nurse manager is responsible for coordinating the internal audit programme with assistance from the assistant nurse manager. A variety of staff meetings and residents meetings are conducted.</p> <p>Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the current facility nurse manager. Care staff complete competencies relevant to their practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur three monthly and the nurse manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available. All residents at the service currently are</p>

environment conducive to effective communication.		English speaking.
<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>Bernadette Lifecare has been a privately owned business and has been managed by a chief executive officer (CEO) who was supported by a nurse manager. The service provides care for up to 113 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 72 residents in total (27 residents at rest home level, 42 residents at hospital level and three young persons with disability).</p> <p>This provisional audit was conducted to assess the preparedness of a prospective provider to provide a health and disability service and to assess the level of conformity of the existing provider's service that is under offer. Information provided by the prospective new area manager, and review of the transition plan identified the prospective purchaser has a plan for the transition and change of ownership which will see the implementation of CHT policies and procedures. The new owners, CHT, have 11 other facilities across the Auckland area. The organisation has comprehensive policies and procedures with which to guide staff. It is CHT's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents.</p> <p>The service is currently managed by the nurse manager who has been in the role for nine years. The nurse manager has reported monthly to the board on a variety of management issues. The current strategic plan and quality and risk management plans have been implemented (February 2014). The nurse manager is supported by an assistant nurse manager, registered nurses and care staff. Both the facility nurse manager and assistant nurse manager have completed in excess of eight hours of professional development in the past 12 months relating to managing the facility.</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</p>	FA	<p>The assistant manager and human resources manager provides cover during a temporary absence of the facility nurse manager.</p>

consumers.		
<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>	PA Low	<p>The quality manual and the business, quality, risk and management planning procedure describe the Bernadette Lifecare's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the quality improvement meeting, and the various facility meetings. Monthly and annual reviews have been completed for all areas of service. Meeting minutes have been maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirmed their involvement in the quality programme. Resident/relative meetings have been held. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2014 has not been fully completed. Areas of non-compliance identified at audits have been actioned for improvement. Specific quality improvements have been identified and benchmarking with external quality indicators occurs on data collected. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies are implemented for individual residents. Residents' are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for January 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data with external quality indicators.</p> <p>The service has reported three incidents under section 31 to the ministry of health which has been acknowledged 19 February 2015. The service is currently working with the district health board portfolio manager regarding the incidents.</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>PA Low</p>	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates are kept. Ten staff files were reviewed. Six of ten files included all appropriate documentation. Staff turnover was reported as currently stable, with some staff having been employed in excess of 20 years. The service is currently recruiting new staff for the addition of 27 hospital beds opened in November 2014. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice as evidenced in eight of ten files reviewed. Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. Care workers are orientated by seniors. Annual appraisals are conducted for all staff as evidenced in eight of 10 files reviewed. A completed in-service calendar for 2014 exceeded eight hours annually and there is an in-service calendar for 2015. A number of care workers have completed an aged care programme, health assistants course of are oversees nurses. The service expects other care workers to commence an aged care education programme. The facility nurse manager, assistant nurse manager and registered nurses attend external training including conferences, seminars and education sessions with the local DHB.</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>Bernadette Lifecare has an eight weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The roster has sufficient staff rostered on to cater for the increase and acuity of residents. There is at least one registered nurse on duty at all times. The full time nurse manager is also a registered nurse. Caregivers and residents and family interviewed advised that sufficient staff are rostered on for each shift. All registered nurses have been trained in first aid and CPR.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential,</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Information containing sensitive resident information are not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts have been stored in a separate folder.</p>

and accessible when required.		
<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	Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission. The service has specific information available for residents/families at entry and it included associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement.
<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	The transfer /discharge/exit procedures included a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation were forwarded with the resident.
<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>	PA Moderate	<p>The service uses individualised medication packs, which are checked in on delivery. Two registered nurses were observed administering medications correctly. Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies, or nil known, were on all 20 medication charts reviewed. An annual medication administration competency was completed for all staff administering medications and medication training had been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. There are four residents currently self-administering medications. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. All residents' identified as self-medicating store their medications in a locked cupboard. Twelve of twenty medication charts reviewed were faxed copies of the original medication chart. As required medication was reviewed by a registered nurse each time prior to administration. Medication charts reviewed identified that the GP had reviewed the resident at least three monthly and the medication chart was</p>

		signed.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals at Bernadette Lifecare are prepared and cooked on site. There is a four weekly winter and summer menu which had been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen. There are four dining rooms for the convenience of residents'. Prepared meals are served directly to the rest home dining room and also transferred to the other three dining rooms. Hospital residents are provided with meals on trays. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Staff were observed assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurse. Supplements are provided to residents with identified weight loss issues or pressure areas. Weights are monitored monthly or more frequently if required and as directed by a dietitian and general practitioner (GP). Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally, as well as verbal feedback to staff. Residents and family members interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The reason for declining service entry to residents to the service would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the resident/family and the appropriate referrer.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and</p>	PA Low	<p>All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission which formed the basis of resident goals and objectives. Assessments are reviewed at least six monthly for hospital and rest home residents. However, pain and nutritional assessments are not always completed for all residents.</p>

preferences are gathered and recorded in a timely manner.		
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Resident files include all required documentation. The long-term care plan records the resident's problem/need, objectives, interventions and evaluation for identified issues. The service has a specific acute health needs care plan that included short term cares. Resident files reviewed identified that family were involved in the care plan development and on-going care needs of the resident.
<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>	PA Low	Care plans are current, however, interventions do not always reflect the assessments and the identified requirements of the residents. Interviews with staff (registered nurses and caregivers) and relatives confirmed involvement of families in the initial assessment and care planning process. Dressing supplies were available and a treatment rooms were stocked for use. Continence products were available and resident files included continence products identified for day use, night use, and other management. Specialist continence advice was available as needed and this could be described. Wound assessment, wound management plans and evaluations were in place for residents, including ten sacral pressure areas. There was documented evidence of specialist input from the district nurse, assistant nurse manager and facility manager (RN). Those residents identified as a high risk of pressure areas have identified nursing interventions implemented including, regular turning schedules, pressure mattresses and regular monitoring and recording.
<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</p>	FA	The activities staff provided an activities programme over five days each week. There is one activities co-ordinator and a diversional therapist at Bernadette Lifecare. The programme was planned monthly and residents received a personal copy of planned monthly activities. Activities planned for the day were displayed on notice boards around the facility. A diversional therapy plan was developed for each individual resident based on assessed needs. Residents were encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. The service has a van that was used for resident outings and a car that is used for resident transport. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.

service.		
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations are comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions (# link 1.3.6.1). Short-term care plans are utilised for residents and any changes to the long-term care plan, such as infection, wounds, use of antibiotics and were dated and signed. Short-term care plans were utilised. Care plans are evaluated within the required timeframes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and or their family/whanau are involved as appropriate when referral to another service occurs.</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</p>	FA	<p>All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. Product use charts are available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided.</p>

hazardous substances, generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The service displays a current building warrant of fitness which expires on 22 April 2015. Hot water temperatures are checked weekly by the maintenance man. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular proactive and reactive maintenance occurs and there is a monthly maintenance schedule in place. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the care, according to the resident needs, as identified in the care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All resident rooms in the older rest home and hospital wing have shared communal toilets and showers. However, some rooms have a toilet ensuite. The new hospital wing all have full ensuites. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Staff and visitor toilet facilities are available. Residents interviewed state their privacy and dignity was maintained while attending to their personal care and hygiene. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal</p>	FA	<p>The resident rooms, including the rooms in the new wing, are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds were of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms are personalised.</p>

space/bed areas appropriate to the consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large lounge and dining room with outside covered seating area. The main dining area is spacious and is adjacent to the kitchen and server. There are also three smaller dining rooms, two in the new hospital wing and one in the older hospital area, each with a small kitchenette and server. There are smaller lounge areas including a visitor lounge and courtyard with seating. There was suitable seating appropriate for the consumer group. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</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>Bernadette Lifecare has monitored the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff. Staff have attended infection control education and there was appropriate protective clothing available. Manufacturer's data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility, which was also evidenced on the day of audit.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and</p>	FA	<p>The service has a fire and emergency procedures manual. The fire evacuation scheme was approved in 1993. The New Zealand Fire Service has reviewed the altered building layout on 4 November 2014 and has confirmed approval in writing for the current evacuation scheme. There is a staff member with a first aid certificate on each shift. Fire safety training has been provided six monthly. A call bell light over each door and a panel in each corridor alerts staff to the area in which residents require assistance. Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. Civil defence and first aid resources were available.</p>

<p>timely response during emergency and security situations.</p>		<p>Sufficient water is stored for emergency use (a tank that holds four thousand litres has been installed) and alternative heating and cooking facilities are available. Emergency lighting is installed. The building is wired up in preparedness for an emergency generator to be plugged in if required. Security checks have been conducted each night by staff.</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 communal and resident bedrooms including the new wing have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was comfortable.</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>Bernadette Lifecare has an established infection control (IC) programme. The infection control programme has been appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. The current facility nurse manager is the designated infection control nurse with support from the assistant nurse manager and the quality team. The IC coordinator and quality team meets to review infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Bernadette Lifecare. The infection control (IC) facility nurse manager has maintained current practice by attending infection control updates. The infection control/quality team is representative of the facility. External resources and support are available when</p>

<p>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>required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on</p>	<p>FA</p>	<p>The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control nurse with support from the assistant nurse manager and human resources manager. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and were advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that are appropriate to their needs and this was documented in medical records.</p>

infection control to all service providers, support staff, and consumers.		Education around infection prevention and control has been provided in 2014 and is scheduled for 2015.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. The facility nurse manager is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly facility infection summary and staff were informed. The data has been monitored, benchmarked and evaluated monthly and annually at the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation is overseen by a restraint coordinator who is the assistant nurse manager. There were 10 hospital residents requiring bedrails or sit-safes as restraint. Seven hospital residents were using bedrails as enablers. The use of enablers is voluntary, requested by the resident. A full restraint assessment is completed prior to implementing the enablers. There is evidence of the residents consenting to the enabler. In addition, there is evidence of monitoring of residents who were using enablers.</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</p>	FA	<p>The restraint coordinator is the assistant nurse manager (registered nurse). Assessment and approval process for a restraint intervention included the restraint coordinator, registered nurse, resident/or representative and medical practitioner.</p>

ongoing education on restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, a registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the five files reviewed (three restraint and two enablers), assessments and consents were fully completed. Consent for the use of restraint was completed with family/whanau involvement and a specific consent for enabler / restraint form was used to document approval.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Low	The restraint minimisation manual identified that restraint is only put in place where it was clinically indicated and justified and approval processes. There is an assessment form/process that has been completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflects risk in four of five files reviewed. Monitoring forms included regular two hourly monitoring (or more frequent) were present in three of five files reviewed. Five files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. The service has a restraint and enablers register which is up dated each month.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	The service has documented evaluation of restraint every six months. In the files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator at quality and staff meetings meeting. Evaluation timeframes are determined by risk levels. The evaluations have been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their</p>	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six monthly or sooner if a need is identified by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly meetings. There are six monthly restraint meetings held.

use of restraint.		
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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 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	PA Low	The service has a comprehensive audit schedule to cover all areas of service that is completed annually and up until August 2014 all audits have been completed as per the schedule.	During the months of August, September, October, November and December 2014 a number of audits have not been completed according to the audit schedule of the facility. This has included (but not limited to): laundry services (not completed during 2014), pressure areas care (not completed during 2014). [The service currently has 10 sacral pressure areas, four heel pressure areas and one toe pressure area. All pressure areas are rated as	<p>Ensure that all audits are completed as per the audit schedule so as to monitor service delivery and address areas that require improvement.</p> <p>90 days</p>

			grade 1 and 2}.	
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. The human resource manager manages the recruitment process and completes a check list. There is a schedule for appraisals.	Four staff files reviewed did not have a job description and two of these files also did not have a current staff appraisal completed	<p>Ensure that job descriptions are completed for all staff and staff appraisals are completed annually for all staff</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. New caregivers are orientated with senior caregivers and complete a skills checklist. All new staff complete an orientation checklist.	One staff member that previously was employed as a cleaner and has been employed as a caregiver since December 2014 does not have all relevant caregiver orientation completed. One staff member employed as a diversional therapist 14 January 2014 does not have any documentation regarding orientation.	<p>Ensure that all new staff and staff that may change designation complete appropriate orientation and that this is documented.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing,</p>	PA Moderate	There are comprehensive medication policies in place, which directs safe medication storage, administration and	Twelve of the twenty medication charts reviewed were a mixture of faxed copies and original	Ensure that any changes to the medication

<p>dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>reconciliation. Any required changes to medication charts are faxed to the GP for updating if the GP is not available onsite at the facility. Original medication charts are to be updated by the GP as soon as practicable to prevent ongoing use of faxed copies.</p>	<p>medication charts. Two faxed medication charts had been in place for a three months and one had been subsequently written on by the GP during a medication review. One faxed medication chart was difficult to read.</p>	<p>chart are updated from the faxed copy onto the original by the prescribing officer as soon as is practicable.</p> <p>60 days</p>
<p>Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Low</p>	<p>There are policies around assessing residents' requirements and goals to guide the level of service delivery.</p>	<p>Six of the twenty medication charts of residents identified with pain did not have a recent pain assessment completed. Two of ten resident files reviewed, who identified with diabetes had no nutritional assessment completed.</p>	<p>To ensure all residents identified with pain have a current pain assessment completed. All residents to have a completed nutritional assessment.</p> <p>90 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>There is documented evidence of assessments and long term care plans completed within the time frames and are goal focused.</p>	<p>In four of ten resident files reviewed long-term care plans were not detailed individually to support residents' care needs and are generic in nature.</p>	<p>To ensure that all long-term care plans reflect the current assessments and offer clear, precise</p>

				instructions and contain detailed resident preferences to care staff and registered nurses regarding individualised care. 90 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	PA Low	Restraint is only put in place where it was clinically indicated and justified and approval processes. There is an assessment form/process that was completed for all restraints and enablers. All five files reviewed had a completed assessment form and four of five files reviewed had care plan interventions documented for each restraint and enabler. Monitoring of restraint and enabler occurred in three of five files reviewed. Staff interviewed were fully aware of residents using restraint and enablers.	(i) One file reviewed of a resident using bedrails as enabler did not have this documented in the residents care plan. (ii) There was no monitoring for one resident using a sit-safe restraint and one resident using bedrails as restraint had two days of monitoring not documented on the monitoring form.	(i) Ensure that all enablers used are documented in the resident care plan. (ii) Ensure that all resident using restraint and enablers have monitoring completed and that this is documented. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.