

Heritage Lifecare Limited - Clutha Views

Introduction

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

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

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

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

The specifics of this audit included:

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| Legal entity: | Heritage Lifecare Limited |
| Premises audited: | Clutha Views |
| 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: 31 August 2016 End date: 1 September 2016 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 47 |

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 |
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|  | 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 |
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| Yellow | 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 |
| Red | 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

Clutha Views provides rest home, hospital – both geriatric and medical - and dementia care services for up to 70 people in Balclutha, South Otago. The service is operated by a facility manager and clinical services manager with assistance from a clinical operations manager and audit and compliance manager at the wider organisation's (Heritage Lifecare Limited) national office in Wellington. Residents and families spoke positively about the care provided at Clutha Views during the audit and this confirmed feedback from recent satisfaction surveys.

This certification audit was conducted against the Health and Disability Services sector standards and the organisation's contract with the Southern District Health Board (SDHB). The audit process included review of the policies and procedures of the facility prior to the on-site audit, review of documents, records and residents' files, interviews with residents, families, staff, managers and one general practitioner.

There are no areas for improvement identified during the audit. An area of strength (continuous improvement) is identified in relation to a staff training initiative.

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.

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 will 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.

Complaints forms are available to residents as are copies of the Code and the complaints process. The facility manager maintains a register of complaints and responds to formal complaints with assistance from senior Heritage Lifecare Ltd. managers. The complaints register is current and up to date.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
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Clutha Views is part of Heritage Lifecare Limited (HLL) a privately owned company which provides aged care services. The facility has operated in Balclutha under a different name for some years also in private ownership until late 2015. Clutha Views is managed by an experienced facility manager and clinical services manager. They have been at the facility for 13 and 20 years respectively.

A strategic business plan for 2016/2017 includes goals for the facility as well as their values and mission. These were reviewed during the development of the plan. The clinical services manager takes on the responsibilities of the facility manager in a temporary absence. She is supported to do this by (HLL) senior managers.

HLL has a well-documented quality management system which is implemented at Clutha Views. This includes a quality and risk management plan, terms of reference for separate functions within the regular monthly meeting and processes for the control and management of documents. Processes are occurring as required by HLL group, these Standards and the contracts held by the facility. Adverse events are reported and recorded by staff members, and the clinical services manager undertakes the monthly collation and analysis of event data. There are clear guidelines for essential notifications and records demonstrated that these are followed.

The facility has a suite of human resources policies and procedures which are used by the facility manager to recruit, select and appoint new staff members and for the management of all staff. Registered and enrolled nurses have their practising certificates validated during the appointment process and monitored annually after this. There is orientation training for all staff when they commence working at the facility or in a new role and ongoing education for all staff members. The training calendar meets the requirements of Clutha Views' scope of services and the needs of residents.

The facility manager and clinical services manager prepare the rosters following a documented process for staffing the facility. This follows the Safe Staffing Levels recommended by the Ministry of Health and is monitored in the manager's weekly report to HLL.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using integrated electronic and hard copy files.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Standards applicable to this service fully attained. |
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The organisation works closely with the 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, podiatrist, physiotherapist, pharmacist) and a designated general practitioner. On call arrangements for support from senior staff are in place. Shift handovers and communication reports guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. 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, 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 an electronic 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. 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

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| 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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Clutha Views is a purpose built aged care facility. There is a current building warrant of fitness and all building checks occur as required. The building is constructed on one level. There are handrails throughout and floor coverings which promote mobility. Residents have safe access to external areas as well as an appropriate range of communal rooms for dining and recreation within the facility. A newly created and opened garden from the secure dementia unit is large, spacious and an improvement on the previous small and inadequate area.

There are guidelines for housekeeping staff on the management waste and hazardous substances and for general cleaning and laundry. Housekeeping staff members monitor the standard of their work and there are regular internal audits which formally monitor all housekeeping services.

Residents' rooms are personalised, have furnishings which are comfortable and in good condition. All bedrooms have external windows which provide natural light and can be opened to allow ventilation.

There are appropriate security and emergency response arrangements in place. Fire evacuation practices occur regularly with an annual practice observed by the Fire Service. Alternatives utilities are available should main supplies fail.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



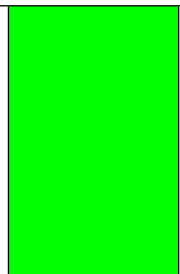
Standards applicable to this service fully attained.

Policies and procedures provide a framework for the safe use of restraints and enablers in the facility. This includes the appointment of a restraint coordinator and an approval group. During the audit there were restraints and enablers in use by residents, following the organisation's procedures. The resident consents to the use of enablers, and families or another legal representative gives consent to the use of restraints.

There is a clear emphasis on minimisation of restraint use wherever possible. Documents reviewed in relation to the use of both restraints and enablers confirms that their processes for use are followed. Staff members monitor the use of restraints and record this as directed. There is monthly reporting the use of restraint and enablers and a register is maintained by the restraint coordinator and clinical services manager. Evaluation of restraint use by individual residents and review overall use in the facility occurs throughout the year as part of the monthly meetings.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The infection prevention and control programme, led by two experienced and appropriately trained infection control coordinators, aims to prevent and manage infections. Specialist infection prevention and control advice is able to be accessed from an external provider and the District Health Board. 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, analysed, trended, 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 | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 1 | 100 | 0 | 0 | 0 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation. | FA | Clutha Views 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. |
| Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood 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, disclosure of health information and advance directives. Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident's records. Staff demonstrated their understanding by being able to explain situations when this may occur. EPOAs are sighted in the files of residents in the secure dementia unit. Staff were observed to gain consent for day to day care on an ongoing basis. |

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| <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.</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.</p> <p>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>There is a complaint policy and procedure which meets the requirements of this standard and the Code. This is accessible to residents and their families within the facility and confirmed at interview during the on-site audit.</p> <p>The complaint register and complaints received during 2016 were reviewed with the manager. She is responsible for the management of complaints with escalation to HLL senior management following a risk matrix. The register is up to date and complaints have been responded to within appropriate timeframes with respectful correspondence which addresses the concerns raised by complainants.</p> <p>Staff members interviewed demonstrated their understanding of the complaints procedure. Complaints and the Code are included at orientation and in the ongoing annual training.</p> <p>While the standard has been met it is recommended that all formal complaints investigations include the opportunity for the complainant to meet with someone and tell them about their experience and concerns.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p> | FA | <p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided, discussion with staff and the facility and clinical managers. The Code is displayed in a range of areas around the facility</p> |

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| their rights. | | together with information on advocacy services, how to make a complaint and feedback forms. |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>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 doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, and exchanging verbal information. All residents have a private room, with double rooms available for couples if requested.</p> <p>Residents are encouraged to maintain their independence and 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 and training.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | FA | <p>Staff verify their ability to support 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. There were no residents in the service who identified as Maori on the days of audit.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic,</p> | FA | <p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, requiring interventions and special needs were included in all care plans reviewed. A resident satisfaction questionnaire includes evaluation of how good residents' cultural needs are met and this supported that individual needs are being met.</p> |

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| cultural, spiritual values, and beliefs. | | |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | <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. 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</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <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, wound care specialist, community dieticians, mental health services for older people, 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 accessing their own professional networks, such as attending infection control interest group meetings and attending DHB training or accessing satellite inservice education, to support good practice. A comprehensive inservice training programme is in place at Clutha Views.</p> <p>A physiotherapist is employed and on site two days per week, enabling residents' to maximise opportunities and independence. The physiotherapist also advises staff on manual handling.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. 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 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, a wide range of staff from varying cultures being available and the use of family members for interpretations if required.</p> |

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| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>Clutha Views is part of the Heritage Lifecare Limited group of aged care facilities. It has previously operated as Chateau Village. The facility provides rest home, hospital – both medical and geriatric – and dementia care services. The facility can accommodate up to 70 residents; 47 beds were occupied on the days of the audit with 20 residents receiving rest home care, 20 hospital level care and seven dementia care.</p> <p>Heritage Lifecare Ltd (HLL) has a senior management team which provides clinical and operational management support to the facility and clinical services managers at Clutha Views. There is a strategic business plan for 2016 – 2017, which includes the vision statement for the facility and its goal – to create and maintain an environment that continuously focuses action on quality improvement in care. There are strategic goals within the plan which link to this overarching goal. HLL took ownership of Clutha Views within the last 12 months. The facility manager reported that their vision and values were reviewed during the development of the current strategic plan to ensure that they are aligned with those of the new organisation.</p> <p>The facility manager has lengthy clinical nursing experience and has managed this facility since 2003. She maintains her nursing practising certificate and attends ongoing professional development appropriate to her role as a nurse manager for the scope of services provided.</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>The clinical services manager has worked at Clutha Views for 20 years, initially as a registered nurse. She has held the role of charge nurse for five years. This position title was changed to clinical services manager with the new ownership but the role is the same.</p> <p>In a temporary absence of the facility manager, the clinical services manager takes over these responsibilities. She is supported to do so with assistance from the HLL clinical operations manager who was present for the audit. Further assistance is available from the HLL quality and compliance manager.</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</p> | <p>FA</p> | <p>Since the change in ownership to HLL a transition process is underway with the facility's documents and systems. The required systems are continuing, and as needed, HLL documentation and / or processes are being implemented.</p> <p>A quality and risk management plan for 2016 and 2017 calendar years is implemented. This plan utilises the HLL group template and incorporates all requirements of this Standard and the facility's contracts. Documents provided for the stage one audit were current, controlled and had been reviewed within a</p> |

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| <p>reflects continuous quality improvement principles.</p> | | <p>specified timeframe. As documents are due for review, the HLL equivalent document is used. Relevant policies and procedures include references to prevention and management of pressure injuries and use of the interRAI assessment tool.</p> <p>A regular monthly meeting is held which covers quality, health and safety, and restraint and enabler use. A standard agenda document and meeting minutes are maintained. The minutes of these meetings for 2016 were reviewed with the facility manager. There is consistent evidence of discussion of quality improvement data, hazards and other health and safety issues, use of restraints and enablers and analysis of all adverse events which have occurred in the last month prior to the meeting. There are additional meetings of the nursing staff and residents and relatives. Minutes of these meetings were also reviewed.</p> <p>The quality system includes processes for identification and development of corrective action plans for individual events which have occurred and in response to trends or systemic issues. Examples were reviewed with the facility manager and seen in response to internal audits completed during 2016. There is a calendar of internal audits to be completed throughout the year and this is being implemented as planned.</p> <p>A current risk register is in place and was last reviewed in July 2016 by the facility manager. It reflects relevant and appropriate risks for an aged care facility the size and scope of Clutha Views.</p> <p>Staff members interviewed are familiar with their responsibilities for quality and risk management. They confirmed that collated quality improvement data is discussed at the monthly staff members and copies of the meeting minutes and graphed data were on display in the staff rooms. Throughout the audit staff members were familiar with the policies, procedures and other guidelines relevant to their roles.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>The facility manager and clinical operations manager were both interviewed during the audit and demonstrated their understanding of requirements of regulatory obligations and essential notification. Evidence was reviewed of appropriate Section 31 notifications to HealthCERT at the Ministry of Health during 2016.</p> <p>There are forms for the reporting of different types of incidents and accidents which are used routinely and appropriately. A copy of any incident/accident involving a resident remains on their file with details of the individual event being maintained on a central register by the clinical services manager. When necessary, corrective action plans are developed and care plans amended in response to events.</p> <p>Prior to each monthly meeting the clinical manager prepares an analysis of all events from the collated data. If any systemic issues are identified corrective action plans are developed and changes made to in-service training to address any opportunities for improvement. Review of the range of documents and interviews with staff members and the managers confirms that adverse event data is used in a range of</p> |

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| | | ways to inform care planning and improvements to service delivery. |
| <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> | FA | <p>A full suite of recruitment and employment policies and procedures are available which cover recruitment, employment, interviewing, reference checks, orientation (for specific staff groups), and ongoing education for all staff members. These processes meet the requirements of these Standards and current good practice in human resources management. The facility manager, with assistance from the clinical services manager, is responsible for the selection and appointment of all staff members. Approval for some positions (registered nurses) is required from HLL senior management. Sampling of personnel files confirmed that recruitment and selection follows the documented policies.</p> <p>During the recruitment process nursing staff members and those who have qualifications relevant to their role have these confirmed before appointment. Once appointed the administrator maintains a register of all health and allied health staff who are employed by or contracted to work at the facility. This register was reviewed and all required certificates were current.</p> <p>All new staff member complete a position specific orientation to their role. A checklist recording this is maintained. Any relevant competencies required of the staff member's position are included in the orientation process. Orientation for all staff has occurred.</p> <p>Ongoing training and development is planned through a combination of in-service training sessions run each month, completion of Careerforce training by caregivers (if they do not already hold a relevant qualification) and accessing appropriate external training when this is necessary to meet the needs of the staff member. Random selection and review of personnel files demonstrated that staff members have completed necessary training to meet the requirements of these Standards and the contracts held by the facility. Nursing staff maintain syringe driver and medication competency in addition to other competencies and relevant ongoing professional development. This enables the facility to meet the needs of residents who require non-acute medical services and end of life care services. Care givers complete the required unit standards for the provision of dementia care. In addition qualifications have been completed which include additional unit standards focused on supporting people with complex needs and dementia and a limited credit qualification specifically for dementia care services was completed and is noted as an area of strength. See criterion 1.2.7.5.</p> <p>Sufficient numbers of registered nurses have trained in, and are competent with, the interRAI assessment tool, to ensure the facility remains up to date with their interRAI assessments. In addition the facility manager has completed interRAI training relevant to her position.</p> |
| Standard 1.2.8: Service | FA | Staffing levels and skill mix policy covers expectation for hospital, dementia and for rest home levels of |

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| <p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | | <p>care. This describes the person in charge, their expected skills, experience and overall responsibilities and the minimum number of other categories of care staff. A general section notes the need for those administering medicines to have a current practising certificate and that an ongoing in-service education programme will be available.</p> <p>Rosters are prepared by the facility manager and clinical services manager for six weeks in advance on a four days on / two days off rolling roster. Rosters were reviewed and demonstrate nursing and caregiver hours are consistent with the Safe Staffing levels. These are used by HLL as the guideline for staffing in their facilities and are included as a guide in their weekly management reports. This was confirmed at interview with the clinical operations manager and by review of the manager's weekly reports. Currently some of the clinical services manager's time is incorporated in the registered nursing hours, in particular for the dementia unit.</p> <p>A range of other positions in housekeeping, kitchen services, activities, maintenance and administration provide further services throughout the facility. There are sufficient numbers of staff to provide safe services in the facility. A recent resident and relatives survey has provided feedback confirming this and those interviewed during the audit also reported that care is provided well.</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 residents' electronic and hard copy records 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</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 facility manager (FM). They are also provided with written information about the service and the admission process.</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 accordance with contractual requirements.</p> |

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| identified. | | |
| <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 organisations transfer form 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 showed 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, using an electronic system 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 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 no residents who self-administer medications at the time of audit, however appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the clinical manager 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. The number of medication errors</p> |

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| | | <p>have reduced since the introduction of the electronic medication system.</p> <p>Standing orders are not used at Clutha Views.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>The food service is provided on site by a qualified cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has just been reviewed by a qualified dietitian and arrived on site the day of audit. Minor recommendations have been made in the report and will be attended to and 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 cook/ kitchen manager has undertaken a safe food handling qualification, with the kitchen assistants enrolled to complete 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 dementia 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. 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> |
| <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>If a referral is received but the prospective resident does not meet the entry criteria 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.</p> <p>There is a clause in the access agreement related to when a resident's placement can be terminated.</p> |
| <p>Standard 1.3.4: Assessment</p> | FA | <p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and the interRAI assessment, as a means to identify any deficits and to</p> |

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| <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | | <p>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 four trained interRAI assessors on site.</p> |
| <p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>FA</p> | <p>Lifestyle care 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 clearly written, informative and relevant. 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.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. 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 an acceptable standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> |
| <p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The activities programme in the hospital, rest home and secure dementia unit is provided by two activities co-ordinators, plus a part time activities co-ordinator.</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 offers a large range of varied activities that match 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. Outings occur on a regular basis as does attendance by visiting community groups. The activities programme is discussed at the residents' meetings and minutes indicate residents' input is sought and 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</p> |

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| | | <p>they find the programme very enjoyable, with lots going on.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living there. The two activities co-ordinators who provide the activities in the unit are trained in caring for residents with dementia, whilst the programme they provide has oversight from a staff member who has just completed training in diversional therapy. A new addition to the unit is a large secure outdoor area that enables residents a view of large open spaces, including those spaces beyond the perimeter fencing. The area includes a washing line, gardening areas, a wind sock, bus stop, a basketball hoop, a farm gate and picnic table. Activities are offered inside and outside at times when residents are most physically active and/or restless. The stimulation level of activities is reduced in the afternoon in preparation for being more settled. Interviews verify staff awareness of residents' interests and ability to attend to these over a twenty-four period. Interviews and documentation verifies a reduced need for medication, improved appetite and improved sleep patterns.</p> |
| <p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, 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 were sighted of care plans being consistently reviewed for upper respiratory tract infections, fluctuating blood sugar levels, and weight loss 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 to meet</p> | FA | <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 GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. 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 (refer 1.3.3).</p> |

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| consumer choice/needs. | | |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>Clutha Views currently uses its own policies, procedures and guidelines. These provide appropriate direction and guidance to staff members on handling waste and hazardous substances. In utility rooms, the cleaners storage cupboard and the laundry, these guidelines are on display and additional information is available to staff.</p> <p>At interview staff members report that they have access to information and receive training. There is ample personal protective equipment (PPE) available for use and accessible for staff. During the recent infection outbreak staff report that they had sufficient PPE to remain safe and undertake their roles effectively. They also described receiving updates on the use of additional PPE specific to outbreaks at the start.</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> | FA | <p>The facility has a current building warrant of fitness and all associated ongoing checks are occurring. Clutha Views has been purpose built as an aged care facility. There are hand rails in all corridors and low rolling resistance floor coverings.</p> <p>Electrical testing and calibration of all equipment occurs and is monitored on a schedule maintained by the manager. Equipment and the schedule was reviewed during the audit and all equipment in use had been recently tested and was in appropriate condition.</p> <p>External areas are available from all exits including a secure garden from the Balmoral (dementia) wing. A new and much larger garden has been developed for the Balmoral wing which is now appropriate and safe for the residents and is a sufficient size for 19 residents when the unit is fully occupied.</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>There is a combination of room configurations at Clutha Views. Some rooms share an ensuite toilets and basins with another room, some have an ensuite with shower, toilet and basin and some have neither, and residents access the additional toilets and showers. In both the Balmoral wing and the other three wings there are sufficient numbers of toilets and showers for residents to have adequate facilities.</p> <p>In addition there are designated toilets for staff and visitors. These are appropriately identified.</p> |

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| <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> | <p>FA</p> | <p>Residents' rooms are individualised and of an adequate size for the provisions of appropriate care. There are designated hospital rooms, which are larger than the rest home rooms, and some dual purpose rooms. Hospital level care is provided in larger rooms to enable the use of hoists, hospital beds and any other mobility aids or equipment required by the resident.</p> <p>Residents interviewed during the audit were satisfied with their 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> | <p>FA</p> | <p>Clutha Views has two large dining / lounge rooms, used by rest home and hospital residents respectively. There is a separate family room which can be used for meetings or privacy and a small seating area at the end of hospital wing.</p> <p>The Balmoral wing has its own spacious dining / living room with access on to the new external area. A second smaller activity / lounge room is also available for use in this wing.</p> <p>Residents were observed using all communal areas throughout the facility during the days of the audit. The lounge areas are large enough to accommodate moving of furniture for different activities and preferences and this was also observed. In the 2016 relative survey, nine of the eleven respondents indicated that there was adequate space and areas for them to spend time with their family member.</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> | <p>FA</p> | <p>Housekeeping staff members were interviewed and described their methods for monitoring the effectiveness of cleaning and laundry. There are a range of guidelines available for specialised cleaning and these were followed during the recent outbreaks. The cleaning products used within the facility have directions for general use and staff are able to access these in their work areas. Day to day monitoring occurs by the individual staff members and internal audits are also completed on a scheduled calendar. These were sighted and a minor issue has been followed up appropriately and was unrelated to laundry effectiveness.</p> <p>Feedback from resident through their regular meetings is positive in relation to laundry services and cleaning of the facility. In the 2016 relative survey 10 of 11 respondents were either very satisfied (seven) or satisfied (three) with cleaning and laundry services.</p> <p>Throughout the time onsite chemicals and products for cleaning and laundry were observed to be either stored securely or in appropriately labelled containers in the cleaners' trolleys. When the trolleys are not in use these are also stored in secure cupboards.</p> |

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| <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>Staff members receive training and information on how to respond to emergencies during orientation and through the annual in-service training. This includes fire safety and evacuation training. The most recent observed evacuation practice was in April 2016 with the NZ Fire Service in attendance. Clutha Views has an approved evacuation scheme which is on display in the entrance to the reception area.</p> <p>There are appropriate alternative energy and utility sources available on site in the event of main supplies failing. Water can be sourced from the header tanks and there are additional gas supplies and a gas barbeque for cooking.</p> <p>Each room has call bells which activate in the appropriate nurses' station (rest home or hospital) and in the corridors. The dual purpose rooms have a device which identifies whether the person occupying the room is either hospital or rest home level to allow for the bell to activate in the relevant location. During the audit the calls bells were observed to be responded to promptly.</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>The facility is heated throughout with a combination of wall mounted fan heaters and ceiling infrared heaters in bedrooms, heat pumps in the lounge/dining rooms and slim line wall heaters in the corridors. The facility was a comfortable temperature during the days of the audit.</p> <p>All bedrooms have large, externally facing windows. Windows can be opened to a safe distance to allow fresh air to circulate. All windows have curtains which are in good condition and when closed cover the whole window.</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 advisor. The infection control programme and manual are reviewed annually.</p> <p>The clinical manager and a RN are the two designated IPC coordinators, whose roles and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CM, FM and the organisation's quality risk manager. Results are presented at the facility's monthly operations meeting which includes all staff.</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> |

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| | | <p>A recent Norovirus outbreak affecting a large area of the southern region earlier this month, resulted in staff and residents being infected with norovirus and the facility going into 'lock down'. Following this outbreak, the facility was subject to an outbreak of an upper respiratory tract virus. Strategies implemented were as per public health outbreak management plan, and implemented under their guidance. Evidence sighted verifies public health's involvement and effectiveness of management strategies by Clutha Views. Analysis of these outbreaks have not been undertaken at this time, due to full resolution of the second outbreak not yet being achieved at the time of audit.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | <p>The IPC coordinators have appropriate skills, knowledge and qualifications for the role. They have undertaken training in infection prevention and control and attended relevant study days as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from an external advisor is available if additional support/information is required. The coordinators have access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinators confirmed the availability of resources to support the programme and any outbreak of an infection.</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> | FA | <p>The IPC 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</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</p> |

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| <p>relevant education on infection control to all service providers, support staff, and consumers.</p> | | <p>orientation and ongoing education sessions. Education is provided by the suitably qualified IPC co-ordinators. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. With the recent infection outbreaks there is evidence that additional staff education has been provided in response.</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> | <p>FA</p> | <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 in the electronic resident care plan. The infection control coordinators review 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 operations meetings, at staff handovers, and the organisation's quality/risk manager. Graphs are produced that identify trends for the current year and comparisons against previous years, and this is reported to the FM, CM and at operations meetings. Data is benchmarked internally within the group.</p> <p>New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</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>Policies and procedures on restraint minimisation and safe practice guidelines are available. These include the philosophy of the organisation which is to minimise their use of restraints. During interview with the clinical services manager and restraint coordinator they both describe this in their practice. Enablers are included and are equipment used by those residents who are able to give consent themselves.</p> <p>All documentation seen prior to the on-site audit and reviewed during the audit is consistent with this Standard. At the time of the audit there are four residents using restraints and four residents using enablers.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for</p> | <p>FA</p> | <p>There are three types of equipment which are approved to be used as restraints at Clutha Views. These are lap and vest belts and bed rails. When a resident is able to consent to the use of any one or more of these items this is considered to be an enabler. When the resident is unable to consent and a family</p> |

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| <p>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>member or other appropriate representative consents on their behalf the equipment is a restraint.</p> <p>There are clear lines of accountability for approval and documentation reviewed outlines this. The two staff members interviewed – restraint coordinator and clinical services manager – described the approval processes as documented in the organisation’s policies and procedures. Meeting minutes in which restraint approval is discussed confirmed the approval process is reviewed.</p> <p>A register is maintained of those residents who have a restraint or an enabler in use. This is updated every month and reflects the changes in use, reviews of need and any other change in status.</p> |
| <p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | <p>FA</p> | <p>As noted, there are processes for all aspects the restraint minimisation and safe practice standard. The files for four residents who are using either restraints or enablers were reviewed. The organisation follows the same process of assessment through to review of the need for the device whether it is an enabler or a restraint.</p> <p>The assessment form includes all the requirements of this standard and all assessments are completed by the restraint coordinator. During interview he reported that he is careful to ensure that all possible alternatives to the use of a restraint are considered before completing the assessment.</p> <p>The assessment includes involvement of the resident (for enablers) or family (for restraints) and the person’s GP. All of the four files reviewed had a completed assessment and consent form on file.</p> |
| <p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p> | <p>FA</p> | <p>At interview with the restraint coordinator and clinical services manager both reported that lap and vest belts are used for the shortest time possible. Only hospital level residents use these devices, either as restraints or enablers.</p> <p>The lounge / activities room used by these residents has two activities staff members on duty from 9am to 3.30pm, Monday to Friday. When these staff members are interacting with residents one-to-one the restraint is removed. The remainder of the time the activities staff, and any caregivers who are available are monitoring those people who are using restraints.</p> <p>Progress notes for each shift record the monitoring of restraint and enabler use. These were reviewed for the four residents files sampled and all have consistent progress notes recorded.</p> <p>In the 2016 relatives survey one respondent completed the question on restraint use. They were very satisfied with the way in which their family member is supported using restraint(s).</p> |

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| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p> | <p>FA</p> | <p>All restraints and enablers are reviewed every three months. The restraint coordinator arranges the meeting with the residents GP, the family or with resident if it is an enabler, and reviews the progress notes and meetings minutes for any issues which may have arisen since the approval for use or the last review. Both the restraint coordinator and clinical services manager emphasised that ongoing need for the restraint is considered and discontinuing the use of the restraint may be an outcome of the review.</p> <p>Meeting minutes and the file reviews confirmed the review process is occurring. The restraint register is tabled at the meeting and reflects detailed information of the use of restraints and enablers and any changes which have occurred during the month and through the review of residents restraints needs.</p> |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | <p>FA</p> | <p>Monitoring and quality review of restraint use is the responsibility of the clinical services manager. At interview she describes this takes place at intervals during the year in the regular monthly meeting, as part of the restraint and enabler discussion. Review of the meeting minutes confirmed that this occurred in May 2016. Overall use of restraints has reduced overtime and emphasis on reduction is evident.</p> <p>Included in the 2016 training calendar was a session on challenging behaviours and de-escalation techniques run by a nurse practitioner specialising in mental health of older people. Completion of additional training by caregiver staff members includes national certificate level qualifications and these include appropriate modules on choice, individual consent and promoting independence and dignity.</p> |

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.

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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 |
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| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to</p> | CI | <p>The facility manager is responsible for planning training for all staff in the facility and there is an annual training plan. This incorporates in-service training sessions, external training and professional development opportunities which meet the needs of individual and groups of staff, and access to relevant national certificate qualification and unit standards learning and development.</p> <p>In 2014 the facility manager identified low attendance and completion rates for caregivers' qualifications and initiated a project to improve this. The project included a change in provider, training of a workplace assessor who also provided assistance and coaching to Clutha Views staff and scheduled sessions to work through each module of identified qualifications required for the facility. These were the New Zealand Certificate in Health and Wellbeing Level</p> | <p>A significant increase in caregivers' completion of training qualifications has contributed to an increase in staff satisfaction, completion of qualifications by 25 caregiving staff in 2014 and 2015 and anecdotally an increase in the quality of clinical care delivery to residents, as reported by the facility manager. This was 100% of the staff who had enrolled in the qualifications with the new provider. At the 2016 local community training and development awards Clutha Views staff made up two thirds of the graduates recognised at this function. The training provider involved has given a testimonial in support of the facility's submission for a sector award in staff training. This also provides additional data and information about the completion rates and satisfaction noted by staff members.</p> |

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| consumers. | | 3 and a Limited Credit programme which included the four dementia unit standards. An analysis of the results of this project was presented during this onsite audit. This 2016 summary of the completed project demonstrates the desired improvement had been achieved. | |
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End of the report.