

Heritage Lifecare Limited - Pururi Court Rest Home and Hospital

Introduction

This report records the results of a Partial Provisional Audit; 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:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Puriri Court Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 October 2016 End date: 20 October 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:	73

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
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

Puriri Court Rest Home and Hospital (Puriri Court) provides rest home and hospital level care for up to 74 residents. The service is operated by Heritage Lifecare Limited and managed by a manager and a clinical nurse manager. Residents and staff spoke positively about the care provided.

This certification and partial provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family and management, staff and a general practitioner.

The audit resulted in two areas of continuous improvement, one in organisational management and one in consumer rights.

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.	All standards applicable to this service fully attained with some standards exceeded.
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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 provided 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.

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

Open disclosure and 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 through the GP link nurse, which contributes to ensuring services provided to residents are of an appropriate standard.

The manager is responsible for the complaints process and this includes the maintenance of a register. The process used meets the requirements of the standard.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Heritage Lifecare Limited are the owners of the business. They have a strategic plan which is used to inform the business plan for each facility. Puriri Court`s plan contains the vision and core values, and goals which are reported on monthly.

The suitably qualified manager is supported by a clinical nurse manager and quality coordinator who are registered nurses.

There is a quality and risk management plan and systems are in place for monitoring the services provided, including regular daily and weekly meetings and weekly and monthly reporting by the manager through to the governing body. This includes an annual calendar of internal audit activity, and monitoring of clinical and non-clinical areas, for example, accidents and incidents, infection control, restraint, wound and pressure injuries, medication management and complaints. Collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where necessary. Meeting minutes, graphs of clinical indicators and benchmarking results are displayed.

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

A suite of policies and procedures cover the necessary areas, are current and reviewed regularly.

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

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

The proposed change to making three rooms into double rooms will not impact on the present organisation management structure. The requirement for increased staffing is in place to meet residents' needs and this will continue to be assessed and met when patient numbers increase.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The organisation works closely with the Needs Assessment and Service Co-ordination service to ensure access to the facility is appropriate and efficiently managed. This ensures sufficient and relevant information is provided to the potential resident/family to facilitate an admission.

Residents` needs are assessed within required timeframes. Registered nurses are on duty 24 hours each day in the facility supported by care and allied health staff, a pharmacist and a designated general practitioner. On call arrangements for support from senior nursing staff are in place. Shift handovers and communication records guide continuity of service deliver and care.

The care plans are individualised and based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any problems that may arise. All residents` records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being 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 handovers being provided.

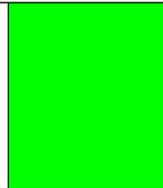
The activities programme provides residents with a variety of individual and group activities and maintains residents` links with the community. A facility van and two buses are available for outings.

Medications are managed safely according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses, all of whom complete annual medication competences.

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

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.

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

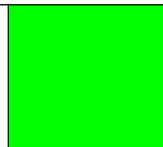
Rooms are of varying size with some ensuites with a toilet. There are additional toilets and showers available. All rooms are of an adequate size to provide personal care related to the services being provided in that area. Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. Laundry services are presently being provided by an external provider while the laundry is renovated. Cleaning is undertaken by staff and is evaluated for effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Security arrangements are defined in policy and staff are trained accordingly.

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.

The organisation has a focus on reducing the use of restraint and this is seen in their policies and procedures and results of monitoring. Four residents were using restraint on the days of audit. Restraint is only used as a last resort when all other options have been explored. An assessment, approval and monitoring process with regular reviews occurs. Three residents had enablers in use and these were being used voluntarily. Staff receive training at orientation and on an ongoing basis, including all required aspects of restraint use, alternatives to restraint and dealing with challenging behaviours. Staff demonstrated a sound knowledge and understanding of the restraint processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme, led by an experienced and trained infection control nurse, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets twice a year. Specialist infection prevention and control advice is accessed from the DHB, laboratory microbiologist, the GP and infectious disease specialists as needed. The infection control programme is reviewed annually.

Staff demonstrated good principals and practice around infection control, which is guided by policies and procedures and supported with regular in-service education.

Surveillance is undertaken relevant to service delivery. Any trends identified are reported at meetings through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	2	99	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Puriri Court 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 and providing options to maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The senior nurses and all registered nurses interviewed understand the principles and practice of informed consent. The informed consent policy is available to guide staff. Informed consent in practice was observed and documentation in the individual resident records verified informed consent was used appropriately using the organisation`s standard consent form as needed.</p> <p>Advance care planning and establishing enduring power of attorney requirements were met. The involvement of the general practitioner was discussed at interview. Staff gained consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy is provided to all residents and family during entry to service. Posters related to the Nationwide Advocacy Service were also displayed around the facility, and additional brochures were available at reception. Families interviewed were informed about Advocacy Services and how to access this and their right to have support persons of their choice as requested.</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>	<p>FA</p>	<p>Residents are encouraged to maintain links with family/whānau and the community by attending a variety of outings, daily walking group activities, visits to the shops, and entertainment events in the community. School and pre-school education visits and music groups are welcomed to the facility and are usually arranged by the activities co-ordinators.</p> <p>Visitors and family/whānau are encouraged to visit the facility and/or to join in the activities programme when able to do so.</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>	<p>FA</p>	<p>Puriri Court has a complaints policy with associated forms that meet the requirements of Right 10 of the Code. The manager stated information is provided to family members on admission and there is complaints information and a suggestions box available at reception and forms are available at the nurses' station. The process was confirmed by staff during interview. Residents and family members spoken with know of the complaints process and who they would approach if they had a problem. The manager has an open doors policy and is available to residents and family members.</p> <p>The compliments and complaints register reviewed contained 52 compliments and 5 complaints for this year, all but one had been closed to the satisfaction of the complainant. The outstanding complaint continues to be investigated for closure. There is evidence of investigation and corrective action being taken where required. The process undertaken for the complaints meets the timeframe of the Code.</p> <p>The manager is responsible for complaints management and follow up. All staff interviewed confirmed they have received related training and demonstrated a sound understanding of the complaint process and what actions are required. Training was confirmed on review of the staff training plan.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	<p>FA</p>	<p>Family interviewed reported being made aware of the Code and Nationwide Health and Disability Advocacy Service on admission to the service. The information is accessible in the comprehensive, well presented information pack provided and on the reverse of the Code pamphlet. The Code is displayed throughout the facility in poster form and pamphlets together with information on advocacy and how to make a complaint,</p>

Consumers are informed of their rights.		which are located at reception.
<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>Policy reviewed included requirements for staff to maintain and protect the confidentiality of residents.</p> <p>All residents and their family/whanau had access to services that promoted independence, they were involved in decision making, and had confidence in their care and management. Support was provided in a manner that was responsive to the residents.</p> <p>Cultural, religious and social needs were identified on the initial assessment form reviewed. Where there were identified needs, these were reflected in the care plan. Values and beliefs were acknowledged by staff. Information regarding local religious groups/resources were available and known to the activities coordinator. Two chaplains are available for this service, a cultural advisor and two kaumatua. A kuia is available on staff.</p> <p>The individual resident`s preferred name was documented on the admission record.</p> <p>The staff verified that residents were supported. The residents interviewed stated that they felt supported by staff and the health care assistant personally assigned to them.</p> <p>Staff understood the reporting process if they witnessed or observed instances of resident abuse or neglect. Education was provided annually as part of the mandatory training on abuse and neglect.</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>Eight staff and three residents identify as Maori. Staff support these residents to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into the day to day practice, as is the importance of whanau to Maori residents. There is a current Maori Health Plan developed with input from the Maori advisor and others. Current access to resources includes the contact details of two kaumatua, and a kuia, who is on the staff at this rest home. Guidance on tikanga best practice is readily available and is supported and respected by staff.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services</p>	FA	<p>Residents and family members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. A cultural assessment is completed on admission to the service. Residents` personal preferences, required interventions and any special needs were included in the care plans reviewed. A resident/family satisfaction survey includes evaluation of residents` cultural needs being met.</p>

which recognise and respect their ethnic, 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>Families interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The general practitioner and the link nurse also expressed satisfaction with the standard of services provided to residents. The orientation process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have attended the required training on professional boundaries. Ongoing education is provided on an annual basis which is confirmed in the training records. Staff are guided by policies and procedures and those interviewed demonstrated an understanding of what would constitute inappropriate behaviour and the processes to follow should this be required.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>The service encourages and promotes good practice for example through use of clinical guidelines, staffing levels in place and management of residents who present with challenging behaviour. Another example evidenced is the Puriri Court continuous improvement programme being implemented. The service has four projects underway to benefit residents, the primary health care assistant programme, Cardiovascular accident (stroke) rehabilitation, wound improvement projects and the service has been involved with health promotion (promoting aged care) by exhibiting at the central library with a health booth in February 2015 and May 2016. The later programme was to raise public awareness of aged care and general health and well-being for aged people in the community.</p> <p>Another project developed and implemented successfully is the appointment one year ago of a 'GP link nurse' role. This role was initiated when the service secured the services of a new facility GP after some difficulty with recruiting the service of a GP for this care setting. The aim was to improve the medical services for the residents at the facility. A survey evidenced excellent feedback and an overall satisfaction rate of 96%.</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 informed about changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported by sighting the family communication record in each resident's record reviewed. There was evidence of family input into the care planning process.</p> <p>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 through the Northland DHB, a national twenty four hour</p>

		interpreter service and locally with assistance of the kaumatua or kuia if needed.
<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>Heritage Lifecare Limited have a strategic plan which forms the basis for the facility specific business plan. The current plan (2015-2016) was developed with input of the senior management team and incorporates the corporate goals, vision and core values and facility goal. The manager stated that the plan is reviewed annually and signed off by the operations manager.</p> <p>The manager receives reports from senior staff which informs their monthly report to the regional operations manager and the HLL clinical quality and compliance manager. The reports are templated and provide evidence against the objectives and key performance indicators. The information provided then goes to the Board. A sample of reports reviewed shows adequate information to monitor performance is reported including, quality and risk, financial information, complaints, and health and safety.</p> <p>The facility has a manager who has a background in a range of areas including administration, with a certificate in small business and a care of the elderly certificate. She has experience in the aged care setting for over ten years, with various roles and has held her present position for approximately eight years. The position description outlines the various delegated authorities and responsibilities held by the manager.</p> <p>The manager is supported by the clinical nurse manager and a quality co-ordinator who are registered nurses.</p> <p>The increase in bed numbers by making three rooms into double will see no change to the organisation or management structure.</p> <p>The facility provides residential care, respite care and hospital level care and on the day of audit there were 26 rest home residents, 45 hospital residents and two respite beds occupied.</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>	FA	<p>When the manager is absent, the clinical nurse manager carries out all the required duties under delegated authority. Support is available from the operations manager and the HLL clinical quality and compliance manager. During the absence of the clinical nurse manager the quality co-ordinator will carry out the duties.</p> <p>This process would not alter with the proposed increase in bed numbers.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a quality and risk plan 2016 – 2018 which is the responsibility of the quality co-ordinator and manager and overseen by the HLL clinical quality and compliance manager. The quality and risk plan reflects the principles of continuous improvement and was understood by the staff spoken with. This includes the management of incidents and complaints, annual audit activities, family and general practitioner satisfaction survey, monitoring of outcomes, clinical incidents, including infections, pressure injuries, falls, skin tears, and quality projects.</p> <p>There is a quality committee which meet monthly and includes senior managers, the health and safety co-ordinator and staff from all areas. The minutes of the quality and risk meetings show that all the usual elements of quality and risk are discussed, and where appropriate, corrective actions are undertaken and reported on at the next meeting until resolved. Staff meeting minutes show quality and risk being discussed and actions reported. Resident and general practitioner survey results show a high degree of satisfaction with the services being provided. Monthly reporting on quality and risk indicators go to the clinical quality and compliance manager and where there is less than 100 per cent compliance a corrective action plan is put into place. The quality co-ordinator spoke of the project work being undertaken, an example being a zero tolerance to pressure injury; this has included staff training and the purchase of more pressure relieving mattresses. There have been no pressure injuries for the past six months. Another project which shows a high degree of commitment to quality assurance, using a corrective action process, relates to the identification of a spike in residents' falls. This is a strength of this organisation.</p> <p>A number of policy manuals are available to guide staff; these include a quality and risk and a nursing manual. There is a process in place for the integration of HLL policies with the Puriri Court policies, and this will occur over time. The present policies meet current good practice and contractual requirements. The document control system ensures a systematic and regular review process of these policies. A few forms were identified as being controlled, but were past their review dates, as were a few obsolete notices. The organisation should consider what further documents are required to be controlled and the setting up of a register to ensure currency and removal of obsolete documents. Staff are updated on new policies or changes to policies through staff meetings. This was confirmed by staff spoken with.</p> <p>The manager provided evidence via the organisational strategic plan of the identification and mitigation of strategic risks. These are reviewed annually as part of the review of the document. The maintenance person undertakes the role of health and safety officer and has undertaken training relevant to the position, including in the Health and Safety at Work Act (2015). There is a hazard register which shows consistent review and updating of hazards as required and an annual review of the full register. New hazards are added to the register as requirements.</p> <p>The facility had tertiary level status with the Accident Compensation Corporation (ACC) last year, however, to date, the new owners have not applied for this to continue.</p>
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<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>Staff document adverse and near miss events on an incident form. This was confirmed by staff during interview and include the prompt reporting of incidents to the registered nurse, who are responsible for the initial investigation of events. The completed form is then sent to the clinical nurse manager for follow up on clinical issues and to the health and safety officer for investigation of hazards. The investigation and follow up is documented on the form. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. There have been no coronial enquires, police investigations or Health and Disability Commissioner complaints.</p> <p>Adverse event data is collated and analysed at the weekly management meeting, with a monthly report to the clinical quality and compliance manager and the manager. Minutes of the quality and risk meeting reviewed showed discussion in relation to trends, action plans and improvements made.</p> <p>The quality co-ordinator and the clinical nurse manager are aware of their requirements to report to external agencies, including reporting to the Ministry.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures reviewed are in line with good employment practice and relevant legislation, and guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. All health professionals (nurses, podiatrist, general practitioner, dietitians and pharmacists), have provided the organisation with a copy of their current APC. This process was confirmed by the manager. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>The manager provided evidence of role specific orientation workbooks that includes all necessary components relevant to legislation, these standards, contract requirements and good practice. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>The clinical quality and compliance manager and manager confirmed that continuing education is planned on an annual basis. The manager provided evidence of the organisation training requirements which includes annual, two yearly and six monthly requirements. The list includes fire and emergency evacuation, abuse and neglect, waste management, the Code of Rights, health and safety, challenging behaviour, infection control, cultural safety, pressure injury, continence, wound management and medications. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The manager is a Careerforce internal assessor. Staff who work in the kitchen have completed food handling courses and there is a plan for cleaning staff to</p>

		<p>undertake their cleaning certificate. Education records reviewed demonstrated completion of the required training. Staff interviewed confirmed continuing requirements to attend training. There is an annual appraisal process for staff.</p> <p>The training requirements meet the needs of the residents and having three further residents will not impact on the present process.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A Good Employment policy covers the contract requirements and includes staffing, levels and skill mix for rest home and hospital, as well as temporary staff arrangements, including a cook, RNs, caregivers and activity co-ordinator. The manager provided copies of the roster which is done two weeks in advance. There is a RN on duty each duty and they are supported during the day, Monday to Friday, by the clinical nurse manager, GP liaison nurse and quality co-ordinator (RNs). The minimum number of staff is provided during the night shift and consists of one registered nurse and three caregivers.</p> <p>The manager spoke of how there is daily communication between her and the staff on the ongoing requirements of the residents and how they can increase staff from the present number of staff if there is a need. This would be implemented when the proposed increase of three residents occurred. She also stated that she has people who are keen to come and work at the facility and have completed application forms.</p> <p>Family interviewed and observation during the audit confirmed that staff are providing services required of them.</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>Resident individual records were reviewed. Records were legible with the name and designation of the person making the entry identifiable. Administration staff maintain the resident register and this is overseen by the manager. The resident's name, date of birth and National Health Index (NHI) number are used on the labels as the unique identifier on all residents' information sighted. The residents' records were integrated with the general practitioner and allied health professionals notes included.</p> <p>There is a process for archiving records, which are held securely on site and can be retrieved if and when required. Residents' records are held in the facility for two years before being placed in a longer term archived area, also on site. No personal or private resident information was on public display during the audit. The individual service agreements are stored in the manager's office in a locked filing cabinet.</p>
<p>Standard 1.3.1: Entry To Services</p>	FA	<p>Residents enter the service when their required level of care has been ascertained by the local Needs Assessment and Service Co-ordination (NASC) service. Families visit the facility prior to admission and there is a process for following these families up regarding placement when appropriate. Resident and families are</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>		<p>provided with information about the service and the admission process. The service provider seeks updates from the NASC service and the GP for residents who receive respite care.</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. Records reviewed contained completed demographic detail assessments and signed admission agreements have been completed in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Discharge or transfers are managed in a planned and coordinated manner. The service facilitates transfer of residents to and from acute care services. There is open disclosure and effective communication between all services, and appropriate information, including the medication records, being provided. All referrals are documented in the progress records and a copy of the referral or transfer form is placed in the integrated records. The resident/family are kept informed throughout all stages of service delivery.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication policy is current and identifies all aspects of medication management in line with legislation.</p> <p>A safe system for medicine management was observed on the day of the 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 medications are competent to perform the function they manage.</p> <p>The service has implemented an electronic system. All eleven registered nurses are fully trained and have completed competencies to manage this process. The education records were available and reviewed. The quality officer has completed weekly audits for the one year the programme has been implemented. Records were reviewed. All allergies and sensitivities are recorded. There is evidence of pharmacy being involved. Some non-regular medication is provided in blister pack form from the contracted pharmacy. Medication reported incidents have decreased since the implementation of the electronic medication system. No residents are currently self-administering medication. A process is documented should this be required.</p> <p>Controlled drugs are checked weekly and are stored securely. A controlled drug register is maintained.</p> <p>The records of temperatures for the medicine fridge reviewed were within the recommended range. The lunchtime medication round was observed and was managed professionally and safely.</p> <p>The GP and link nurse interviewed are pleased with this relatively new system. All other GPs involved are familiar with this medication process in place. There was evidence of the GP reviewing the medications on the records reviewed.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is managed by a qualified chef who is supported by experienced kitchen hands. The summer menu plan is commencing next week. This consists of a four weekly cycle. The menu plans are reviewed by a qualified dietitian every two years. All staff have food handling certificates which are displayed in the kitchen. The service has developed and implemented a Food Control Plan for Heritage Lifecare Ltd and this has been audited by the District Council effective from 20 July 2016 until 31 July 2017. This is a new requirement for the Ministry of Primary Industries. A diary is completed daily and general tips for cleaning and/or hygiene are documented in the diary for staff.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with the above legislation. The personal food preferences, and any special diets or modified food required are made known to kitchen staff and accommodated in the daily meal planning. Special equipment if available to meet the needs of residents if needed.</p> <p>Evidence of satisfaction with meals is verified by resident/family/whanau interviews and some responses from satisfaction surveys reviewed. Residents were observed being assisted as required with meals and were given adequate time to eat their meals. There is sufficient staff on duty in the main dining room at mealtimes to ensure assistance is available to residents as needed. A second dining room was also available and this was supervised and assistance was available if 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>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria, or there is currently no vacancy, the local NASC service 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 sent by the GP or the link nurse and a new placement is found, in consultation with family/whanau. Examples of this were discussed with the clinical nurse manager. There is a clause in the access agreement related to when a resident's placement can be terminated. High needs dementia care Level 3 is not provided at the facility.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools such as the interRAI assessment. In addition, and as required to meet the needs of individual needs of residents, other assessment tools are utilised such as, a Coombes assessment tool for monitoring falls risk, nutritional assessment, balance and gait mobility assessments, continence, and other tools are available. The care plan is then updated by the registered nurse to ensure currency.</p> <p>The sample of care plans reviewed had an integrated range of resident related information. All residents'</p>

manner.		have current interRAI assessments completed by one of the trained registered nurses. Seven of eleven registered nurses are fully trained and able to perform the interRAI assessments. The clinical nurse manager is also fully trained to undertake assessment and reviews of residents in a timely manner and if a resident's condition changes.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	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, medical and allied health professional's notations clearly written, informative and relevant. Any changes in care required is documented and verbally passed on to relevant staff. Families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation reviewed verified provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a range of individual needs was evident in all areas of service delivery. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed and care is managed effectively. The role of the link nurse has been very beneficial and both the link nurse and the GP worked collaboratively together with the interest of the residents at the forefront. Adequate resources and equipment was available, suited for this aged care setting and in accordance with meeting the residents' needs.
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.	FA	<p>The personal activities plans are developed by the two activities co-ordinators, signed off and dated. All activities care plans are up to date. The activities co-ordinators meet regularly with other co-ordinators working in aged care settings in the region on a regular basis. Meetings are formalised with meeting minutes documented and sighted. Exchange of ideas, networking and other information is shared. The residents on the day of the audit had attended an `Olympic Games` event with ten other aged care facilities and residents interviewed on their return were pleased with their team and individual achievements.</p> <p>A social assessment and history is undertaken on admission to the service to ascertain resident's 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 six monthly or more often if required. This occurs at the time of care plan review and progress is highlighted. Resident meetings occur and meetings are available for review.</p> <p>The planned monthly activities programme reviewed matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, patterns of life and include community activities, individual group activities and regular events are offered. The programme is displayed weekly. A music</p>

		<p>session was available in the afternoon of the first day of the audit and residents and visitors were observed enjoying the programme. The resident/family surveys demonstrated satisfaction with the programmes and that information is used to improve the range of activities offered.</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 records. The care staff report any changes to the registered nurses on each shift if observed.</p> <p>The care plans are evaluated every six months in conjunction with the six monthly interRAI assessment or as required if resident's individual needs change. Evaluations are documented by the registered nurses. Where progress is not as expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being used were verified. Family/whanau interviewed provided examples of involvement in the evaluation process. Family who are overseas are kept informed electronically (by email) and this is recorded on the family communication record.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) 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>Residents are supported to access or seek referral to other health and disability service providers. Residents can choose their own GP or use the resident GP. Copies of any referrals were retained in each individual resident's record reviewed. Examples included radiology, mental health, dental, eye specialist, surgical and medical outpatient clinics at the DHB.</p> <p>Any referrals are followed up on a regular basis by the link nurse or the GP. The family are kept informed of the referral process, as verified by documentation and family interviews. Any acute/urgent referrals are attended to immediately, such as sending a resident to the DHB if and when required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated</p>	FA	<p>Documented processes for the management of waste and hazardous substances were in place, including segregation of waste, recycling and detailing procedures for blood and bodily fluids management and disposal. Waste is removed by a private company twice a week or more frequently if required. A yellow bin for biohazard is available if required, sharps boxes are also available. Food waste is via a documented agreement with a pig farm, who provide the organisation with details of how they meet statutory requirements.</p> <p>Chemicals were seen stored in locked areas, sluice rooms, cleaning cupboards and outside sheds. One is delegated as the hazardous chemical storage shed, with appropriate signage, the area is also used for the storage of equipment. In discussions with the manager and the maintenance person, the equipment is being moved to a more appropriate area. Appropriate staff have undertaken training in chemical management as</p>

<p>during service delivery.</p>		<p>sighted in staff files.</p> <p>An external company is contracted to supply and manage most chemicals used for cleaning and in the laundry. The company provides a monthly report, a sample of which was sighted. Material safety data sheets were available for the chemicals provided by the external company and these are stored safely.</p> <p>There is provision and availability of protective clothing and equipment, including gloves, goggles, hard hat and plastic aprons. Staff were observed using gloves appropriately and could identify when they would use protective equipment when interviewed.</p> <p>There is no implications for the management of waste or safe storage of chemical by the proposed addition of three beds.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness expires December 2016 shows the building and fire signage and exits meet legislative requirements. This is displayed in the reception area. Overall, the facility is fit for purpose and no building changes would be required with the addition of three further beds, as they would be accommodated within the parameters of three present rooms.</p> <p>Reactive maintenance includes the use of a book in the hospital area where staff write in required maintenance issues they identify and the maintenance person checks the book daily. If the matter is more urgent then they can contact the maintenance person by the facility call system. Staff interviewed confirmed they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned. The maintenance person has a list of maintenance to be carried out at a frequency identified by the organisation. The folder when reviewed had some areas incomplete and the manager and the maintenance person have re-prioritised these and a process for reporting and monitoring has been put in place. The maintenance person, is trained to undertake electric testing and tagging of equipment and this is current. The calibration of bio medical equipment is undertaken by an external contractor and this was up to date. The sanitiser maintenance is overdue but the manager provided evidence that this is to be undertaken at the end of the month. Some rooms and corridors had chipped surfaces and need re-painting. An updated proactive maintenance schedule has been developed to ensure the whole of the facility will be reviewed and maintenance carried out on a rotational basis.</p> <p>The maintenance person undertakes regular monitoring of the hot water temperature which shows this is being maintained at the required temperature for residents' safety.</p> <p>There are several external areas that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents and family members interviewed and the family satisfaction surveys results show that they are happy with the environment.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is a mix of toilet and shower facilities. This includes rooms with ensuites and communal toilets and showers. An adequate number of accessible showers and toilets are identified throughout the facility. Some door ways are small, but staff spoken with state they do not have difficulty assisting the present residents in and out of these door, but they would cause difficulty if a resident required a shower trolley, which the facility does have but is presently not using. Staff and visitor toilets are available and are separate from residents' toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p> <p>The addition of three further beds would not put a strain on the present number of toilets and showers.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There are a variety of shapes and sizes of rooms. Each room is of a size that meets the needs of the present rest home or hospital level residents, which allow for adequate personal space for residents and staff to move around within the bedrooms safely, including with the use of mobility aids. It was observed that rooms can be personalised, with some having their own furnishings, photos and other personal items displayed.</p> <p>A visit to the three rooms proposed for double rooms, with the manager and clinical quality and compliance manager, provided evidence that the personal space of each resident would not be compromised by an additional person, with sufficient space for staff to assist the residents with equipment. (The room numbers were 78, 20 and 17), One room will require the removal of a large vanity to allow for sufficient space, and one of the beds would be close to a ranch slider which would in effect become a window. There is a window beside the sliding door which can be opened. This is not a fire exit door. Another of the rooms was already being occupied by two residents, a husband and wife. There were rails for privacy curtains but these were not in place. The facility agreement was signed to show agreement to share a room and that they did not wish a privacy curtain to be put up at this time. The use of privacy curtains would be available in the proposed three rooms. In addition, the auditor was asked to assess whether a further four rooms would be acceptable for two residents, these were seen as being too small to allow for personnel space and to allow for staff with equipment such as hoists to access the resident if two beds were installed.</p> <p>There are areas for the safe storage of mobility aids, such as walking frames, hoists and wheel chairs. Staff reported the adequacy of bedrooms</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>A number of communal areas are available throughout the facility to allow for residents to engage in activities. There are also dining areas. These communal areas are spacious and enable easy access for residents and staff. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely.</p> <p>These areas will continue to meet the requirements with the three proposed additional beds.</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>The in-house laundry is presently being renovated with new equipment being installed and doors being added to allow for a clear clean to dirty flow. Presently the laundry is being undertaken by an external service. This service has undertaken external health and safety accreditation of its services, a copy of the certificate being sighted. Dirty linen is picked up from the present laundry area and the clean linen delivered to the reception area for distribution to the areas for storage. Personal items are still being washed by staff in a small domestic washing machine. Residents and family members interviewed reported the laundry is managed well. Laundry staff, some of whom undertake cleaning and kitchen duties, have undertaken chemical training and the manager stated they would be given education on the use of the new equipment.</p> <p>There is a cleaning team, one of whom has recently been employed, she has been given an orientation to the role by a cleaning staff member. However, not all the practices sighted meet the policy of the organisation and this was amended during the audit. Chemicals were stored in the locked cleaners' cupboard, with dilution being undertaken by the maintenance person. All containers were labelled with the manufacturers labels. Cleaning and laundry processes are monitored through the internal audit programme and by the chemical company representatives.</p> <p>These areas will continue to meet the requirements with the three proposed additional beds</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an Emergency Procedure manual which guides management and staff in emergency planning, preparation and response in the event of a fire or other emergencies. The current fire evacuation plan was approved by the New Zealand Fire Service in October 2016. Trial evacuations takes place six-monthly and a record is kept of which staff attend. A few staff have not attended a trial evacuation this year and the manager is aware of this and will take action to ensure these staff complete the next evacuation. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's meet the requirements for the number of residents.</p>

		<p>Call bells alert staff to residents requiring assistance.</p> <p>The facility is locked at dusk by staff and entry can be gained by an intercom system. Outside areas have lighting which is activated by sensors and there is a close circuit television system which monitors 15 areas including the front entrance and medication safes. If staff have concerns they are to call the police.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas have opening external windows. Heating is provided by heated air vents in the ceiling and the temperature of the facility is monitored. Areas were warm and well ventilated throughout the audit and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual with policies and procedures for staff to access as required. The infection control programme and manual is reviewed annually.</p> <p>A registered nurse quality officer is the designated infection prevention and control co-ordinator, whose role and responsibilities are defined in a job description. Any infection prevention and control matters and infection control surveillance results are reported monthly to the quality and compliance manager at head office.</p> <p>Infection prevention and control signage is available such as `washing hands` reminders and posters are displayed. Staff stated that they understood responsibilities if they are sick and need time off work, and know when to come back to work.</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</p>	FA	<p>The infection prevention and control nurse (ICN) has the appropriate skills, knowledge and qualifications for the role, and has been in this role for five years. The ICN works closely with the clinical nurse manager and the link nurse. The ICN has attended an infection control seminar this year at the DHB and other registered nurses have also attended this course. There are well established networks with the infection control team at the DHB being available for expert advice. The microbiologist at the local laboratory service is also available for additional support and information when required. The ICN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p>

<p>and meet the needs of the organisation.</p>		<p>The infection control committee meets two times a year, and should an outbreak occur, they would meet immediately and on a regular basis until the situation was fully controlled. The committee consists of the facility manager, the infection control nurse, a kitchen representative, the clinical nurse manager, two registered nurses, a cleaner and a staff member from the laundry.</p> <p>The ICN 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>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current good practice. Policies and procedures were last reviewed within the last two years. Appropriate referencing is used. All staff at the time of the audit were observed following organisation policies, such as appropriate use of hand sanitises, good hand washing techniques and the use of disposable personal protective equipment such as hats, aprons and gloves. Handwashing facilities are available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection control education was observed on the education plan for 2016. Interviews, observation and documentation verified staff have received education in relation to infection prevention and control at orientation and ongoing education sessions. Education is provided by the ICN and registered nurses and external providers when arranged. This is usually two times a year as per the annual education plan. A record of all in-service education is maintained and attendance records of staff was verified.</p> <p>Education of residents is generally on a one-on-one basis and has included education on handwashing and increasing fluid intake if required. When an outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. There have been no outbreaks for one year.</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 for the nature of this service. The infection control form is completed for all infections for the rest home and hospital services. These include urinary tract infections, soft tissue, eye infections, gastro-intestinal, upper and lower respiratory infections, scabies and other infections.</p> <p>When infection is identified, a record of this is documented in the clinical records. The ICN reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and any required actions. Results of surveillance are shared with staff through the staff and quality meetings and at handover between the shifts if necessary. Graphs are produced that identify any trends and this is displayed for staff to view. Minutes are maintained for all meetings held.</p> <p>Education is provided based on results of the monthly reports and comparative studies are maintained by the ICN as needed.</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>The quality co-ordinator is also the restraint co-ordinator and has a job description outlining the responsibilities of this role. There is a Restraint Minimisation and Safe Practice policy which documents a commitment to a restraint free environment which was also voiced by the restraint co-ordinator. Restraint use has reduced over the years, with 30 restraints being recorded in 2014 and down to the four presently being used. The policy meets the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers.</p> <p>On the day of audit, three residents were using enablers. A review of two residents who are using enablers and one with restraint shows that the processes are being followed, with one exception. One resident had a bed rail in place when the auditor spoke with them and this was not recorded in his file as an enabler. The resident can request the rail to be put down. The restraint co-ordinator is following up this breach of policy.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident in the files reviewed of those residents who have approved restraints and from interview with the restraint co-ordinator.</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</p>	<p>FA</p>	<p>The restraint approval group, is made up of the clinical nurse manager, restraint coordinator, facility manager, GP and registered nurse. The group are responsible for the approval of the use of restraints and the restraint processes, as defined by policy. The members of the restraint group are also members of the monthly managers' meetings where the approval and review of restraints are discussed and agreed. It was evident from review of meeting minutes, review of residents' files and interview with the restraint coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family who have Enduring Power of Attorney (EPoA) involvement in the decision making, as is</p>

<p>restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>required by the organisation's policies and procedures, was on the restraint consent form in the resident's file where restraint is in use. The restraint approval form identifies all area of risk outlined in the standard.</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>Assessments for the use of restraint is documented on an assessment form that included all requirements of the standard. The initial assessment is undertaken by a registered nurse with the sign off by the restraint minimisation group, with input from the resident, and family with EPOA. The restraint co-ordinator described the documented process. The GP signs off the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of residents who were using a restraint and all signed appropriately within a tight timeframe.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>Restraint monitoring forms are used to record each episode of restraint use. When restraints are in use, hourly monitoring occurs to ensure the resident cares are being met with recording of toileting, food and drink being given and that the resident remains safe. The monitoring form is kept in the resident's file and used by the restraint coordinator for monitoring of the usage and conformity to policy. This was seen completed in two of four residents' files where restraint is in use. The forms' reviewed clearly indicate when the restraint is put on and taken off and cares given. However, staff are not completing the form in a consistent manner, using abbreviations, different columns for the information, this did not detract from the purpose of the form and it was clear when the restraint was in use and not and met the requirements of the standard. The restraint co-ordinator agreed that further education on completing the form is needed.</p> <p>A restraint register is maintained, updated every month, or more frequently if required and reviewed at each manager's meeting. The register was reviewed and there is evidence of review occurring.</p> <p>Staff spoken to understand that the use of restraints is to be minimised and how to maintain safe use was confirmed.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files evidenced the individual use of restraints is reviewed and evaluated monthly, and three monthly as part of the lifestyle care plan reviews, with input from the resident, family, where ever possible, and staff. The evaluation includes all requirements of the standard. Where a decline in the use of restraint is observed a trial without the bed rail is occurs for three days and a further evaluation is undertaken. There is documented evidence of three monthly evaluations by the GP.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee review all restraint use on an annual basis, which includes all the requirements of this standard. The restraint co-ordinator carried out a monthly audit, the results of which go to the clinical quality and compliance manager and are part of the annual review. Minutes of the restraint group meeting confirmed analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use and the appropriateness of restraints. Restraint use is reported to the quality meetings and is an item on the staff meeting agenda. Any changes to policies, guidelines, education and processes are implemented if indicated.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The GP link nurse role was promoted within the GP recruitment information allowing an opportunity for residents to receive a GP service in an alternative form. This role has developed over the last year and the link nurse interviewed explained this process and how the role works to enhance residents' understanding of their health issues and wellness. The link nurse liaises with the NASC team and attends all multidisciplinary meetings and provides support to the multidisciplinary team and families. The role ensures follow-up of all laboratory results, preparing for GP rounds and visits and liaising with the pharmacy and ensuring medications are supplied as prescribed. The link nurse is also a trained interRAI assessor. The RNs are kept fully informed of all aspects of the residents' health care needs. The link nurse is respected by GPs, colleagues and meets regularly with the facility manager and clinical nurse manager. The changes have enhanced the delivery of care received by the residents through the introduction of the GP link nurse role.</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis process of the GP link nurse role. This role provides invaluable quality, competent, clinical care that enhances the wellbeing of residents, supporting and providing collaborative care with peers and other providers within the wider health system. There is an increasing ability of the GP link nurse to participate in quality improvement activities. The results of the GP link nurse survey (September 2016) provides evidence on the success of this role.</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>CI</p>	<p>There are corrective action plans used when the organisation's quality indicators are less than 100 percent as identified via audit, this was confirmed by the quality co-ordinator and the clinical quality and compliance manager.</p> <p>The minutes of meetings (quality and risk, staff meetings and the health and safety meeting), show evidence of non-conformity or issues being identified via audit, complaints or incidents, that result in a corrective action processes being undertaken. The actions are reviewed to ensure a positive outcome and monitoring to ensure ongoing compliance.</p> <p>The quality co-ordinator spoke of quality projects which have resulted from less than optimal performance against clinical indicators and have resulted in a corrective action process being put in place. One that is currently being implemented is the zero tolerance to pressure injury. Another project, which has seen positive outcome for patient care, is the falls prevention and awareness quality improvement initiative.</p> <p>The project was a response to what the organisation recognised as an unacceptable rate of residents falling. This was identified by clinical indicator data for the organisation. Data was analysed and trended for 2015 and the first five months of 2016, which included the number of falls and the consequences for patients, and showed an increasing number of falls for two of the months in 2016. Data collected included details around fall location, time and activity. A corrective action process, including root cause analysis, was undertaken. Based on this data a falls awareness and prevention strategy was implemented. This included an eight-step evaluation and intervention process:</p> <ul style="list-style-type: none"> - Evaluate and monitor resident for 72 hours after the fall - Investigate fall circumstances - Record circumstances, resident outcome and staff response - Alert the General Practitioner - Implement immediate intervention within first 24 hours - Complete falls assessment - Develop plan of care - Monitor staff compliance and resident response, which was fed back to staff at their meetings. 	<p>Data showed a high rate of falls for the hospital and rest home. In 2015 there were 85 falls in total. In 2016, in February to May, there was a total of 50 falls reported. The falls key performance indicator (KPI) among the rest home level care residents was 10.51 and 9.65 in February and May respectively. Since the implementation of the falls awareness and prevention strategy there has been a steady decline in falls numbers, the total number per month being: June - 11; July - 6; and August -7.</p>
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End of the report.