

Heritage Lifecare Limited - Roseneath Lifecare

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:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Roseneath Lifecare
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: 7 June 2017 End date: 8 June 2017
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:	40

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Roseneath Lifecare provides rest home, hospital and dementia care for up to 46 residents. The service is operated by Heritage Lifecare Limited (HLL) and managed by a facility manager and a clinical manager. Residents and families spoke positively about the care provided.

This certification 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 members, management, staff, and a general practitioner.

This audit has resulted in one continuous improvement related to medication management and identified two areas requiring improvements relating to analysis of collated data and 24 hour activity plans for residents in the dementia unit.

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.
--	--	--

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provided residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

Information about complaints was available throughout the facility. A complaints register is maintained and complaints are resolved promptly.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
---	--	---

A quality and risk management plan includes the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection of quality improvement data. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
---	--	--

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

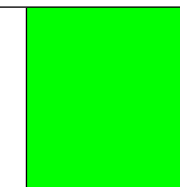
The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

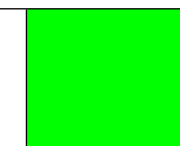
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group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

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment was tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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 implemented policies and procedures that support the minimisation of restraint. Four residents were using restraints at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler 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>
--	--	---

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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, 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	48	0	2	0	0	0
Criteria	1	97	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Heritage Lifecare Limited - Roseneath Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>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.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and was documented, as relevant, in the residents' records reviewed. Staff were observed to gain consent for day to day care.</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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. 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>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 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' families 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>	<p>FA</p>	<p>HLL has a complaints and concerns policy, and associated forms, which meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Staff members interviewed understood their responsibilities for responding to complaints and concerns raised and family members interviewed were also aware of how to make a complaint.</p> <p>The complaints register reviewed showed that four complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed follow up to the issue raised and improvements have been made where possible. The facility manager is responsible for complaints management and follow-up, with reporting through to the operations manager and quality and compliance manager.</p> <p>Resident meeting minutes record discussion of any minor issues or concerns they may have during their regular meetings.</p> <p>There have been no complaints received from external sources since the previous on-site audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided. Families of those in the dementia wing during interview demonstrated a good understanding of consumer rights. The Code is displayed on entrance to the facility together with information on</p>

		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. Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities of their choice. Care plans 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 was confirmed to occur during orientation and annually.</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 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. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and was supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respected their individual cultural needs.</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, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and families verified that they were consulted on resident's individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example having communion in their room on specific days. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any sign of abuse.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, wound care specialist, a psychogeriatrician, and mental health services for older persons, and education of staff.</p> <p>The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included full implementation of an electronic medication management system including routine audits.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members stated they were kept well informed about any changes to 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 in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The purpose, values, scope, direction and goals of the organization are reviewed annually. Currently these are included in the quality and risk management plans for each facility. A generic document is provided to each facility from Heritage Lifecare's board once their annual two day planning meeting is completed. As well as the vision, mission and values of the organization, there is an overall goal. Each facility develops their own objectives. (See standard 1.2.3 Quality and risk management.) The organization is governed by a private board of directors. Reporting to the board is a senior management team made up of two operations managers, a quality and compliance manager, a human resources managers, chief financial officer and facilities manager. They are led by a general manager who reports to, and is a member of, the board.</p>

		<p>A sample of weekly reports from the facility manager to the operations manager and the quality and compliance manager were reviewed. These showed that adequate information to monitor performance is reported including occupancy, financial performance, human resources updates including recruitment and staff training, emerging risks and issues. The quality and compliance manager was present for the audit and confirmed that these reports are sufficient to enable monitoring of service delivery.</p> <p>The service is managed by a facility manager who has been at Roseneath since May 2016 and has held management positions in the health and disability sector for 14 years, with the last six years at another aged care facility in the Wellington region. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending the annual HLL managers conference, external training relevant to her role and in-service training provided by HLL.</p> <p>The service holds contracts with their local District Health Board for respite, health recovery and palliative care, as well as the age related residential care and aged related hospital specialised services at the time of audit. On the day of the audit the service was supporting 15 residents receiving hospital level care, 12 residents receiving dementia care and 12 residents receiving rest home care. One resident was admitted during the day under their respite contract for palliative care, bringing the total to 40 residents on the first day of the audit. The total available beds in the facility are 29 dual use, 13 dementia and 4 rest home.</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 facility manager is absent, HLL uses an experienced facility manager who works on an as needed basis covering the annual leave of their managers. This person carries out all the required duties under delegated authority with the assistance, as needed of the operations and quality and compliance managers.</p> <p>During absences of the clinical services manager, the clinical management is overseen by the operations manager and/or quality and compliance manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise.</p> <p>Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	PA Low	<p>HLL has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of adverse events (accidents, incidents, infections and complaints), internal audit activities, a regular resident satisfaction survey, monthly monitoring of</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>clinical indicators (which include adverse events) by the clinical manager and weekly compliance reporting by the facility manager.</p> <p>Regular quality meetings, restraint meetings and infection control meetings are held and minutes are maintained. At interview with the facility manager, she confirmed that quality indicators and related information is reported and discussed at relevant meetings. Meeting minutes are consistently maintained, however while the organisation has a process for analysing collated quality improvement data, this information is only being summarised on a monthly basis and there is no analysis occurring which would enable identification of trends or service shortfalls. An area for improvement is identified in relation to this, and this also links to standards RMSP 2.2.5 and IPC 3.5.7.</p> <p>Staff reported their involvement in quality and risk management activities through reporting and recording adverse events, internal audit activities, and the range of staff and committee meetings. Relevant corrective actions are developed and implemented to address any issues in response to individual adverse events, during committee meetings. Corrective action plans are also developed by both the operations manager and quality and compliance manager when they have identified systemic issues. Evidence of a range of corrective actions was reviewed.</p> <p>Resident satisfaction surveys are completed annually. The most recent survey, completed in January 2017, had an 89% overall satisfaction rating.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. This is maintained at the organisation's national support office and new or updated policies are provided both electronically and in hard copy.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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</p>	<p>FA</p>	<p>There are documented processes for essential notification. The facility manager described these procedures and provided examples of two notifications made since the last audit, both of which related to pressure injuries.</p> <p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Monthly meetings include discussion of</p>

<p>family/whānau of choice in an open manner.</p>		<p>adverse events and the response to these and any follow up action which may be required. Adverse event data is collated, summarised (see finding 1.2.3.6) and reported to HLL support office.</p> <p>Staff members interviewed understood the process for reporting and recording adverse events and confirmed that they regularly receive information about summarised adverse event data.</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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Professional registration and APCs for all employed and contracted health and allied staff was confirmed during the audit visit.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on a biennial basis, including mandatory training requirements. 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. Staff working in the dementia care area have either completed or are enrolled in the required education. The activities coordinator employed at the time of the audit was in the process of completing her diversional therapy qualification. The facility had also recruited and appointed a trained diversional therapist who was commencing work at Roseneath on 19th June 2017. This person's qualification's and employment documentation was sighted during the audit. (Their current registration expires July 2018).</p> <p>The registered nursing team are provided with both in-service and external training and development opportunities to meet the requirements of these standards, the providers contract and the needs of the residents. There are also sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals for staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there was adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. The January 2017 resident satisfaction survey results showed a 92% satisfaction rate for nursing care, 94% for personal rights and 100% for domestic service.</p> <p>Observations and review of a six -week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</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>	<p>FA</p>	<p>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. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<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 are provided with written information about the service and the admission process. The organisation seeks updated information from the needs assessment service co-ordination (NASC) service and general practitioner (GP) for residents accessing 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. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. There is open communication between all services, the resident and the family. At</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>the time of transition between services, appropriate information 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 fully documented information was provided including any risks. 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>	<p>FA</p>	<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. Weekly audits occur identifying any gaps and has shown continuous improvement and outcomes for a resident in the dementia wing.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly/on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. 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. Standing orders are used, are current and comply with guidelines.</p> <p>There are no residents who self-administer medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>The food service is provided on site by a cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local authority. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was 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.</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 is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. 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> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning.</p> <p>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. Residents and families confirmed their involvement in the assessment process.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' 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</p> <p>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.</p> <p>The GP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. 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</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>The activities programme is provided by an activities person undertaking diversional therapy training with oversight of a trained diversional therapist (DT) holding the national Certificate in Diversional Therapy, and a rostered volunteer. The facility has employed a DT to commence on June 19th to assist in the dementia wing.</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 three monthly and as part of the formal six monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through residents' meetings. Residents and families interviewed confirmed they find the programme provides a variety of activities of interest to them.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless, however the 24 hour plan does not include activities over a 24 hour period and</p>

		this requires improvement.
<p>Standard 1.3.8: Evaluation</p> <p>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. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, falls, skin tears. When necessary, and for unresolved problems, long term care plans are added to an updated.</p> <p>Residents and families 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 consumer choice/needs.</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, including to the wound nurse specialist and psychogeriatrician.</p> <p>The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary in the laundry and utility rooms.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using these during the on-site audit. Staff interviewed confirmed there were ample supplies available.</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 which expires on 21 June 2017 was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current as confirmed in documentation reviewed, interviews with the facility manager and observation of the environment.</p> <p>The environment was observed to be hazard free, residents were safe and independence was promoted. External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>A one bedroom cottage separate from the facility is approved for use by a subsidised resident. The entrance is via steps which has an inadequate handrail and would not be suitable a subsidised resident. However, the provider does not use the cottage for the provision of certified services and has not intention to do so. The cottage is currently occupied under a private rental arrangement.</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 are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a combination of ensuite toilets, shared bathrooms and shared toilets for residents, and toilets for staff and visitors.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence and safety.</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>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. With the exception noted below, all bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Family, residents and staff reported the adequacy of bedrooms for residents needs.</p> <p>As noted in the previous audit report, two bedrooms have been reconfigured into one large bedroom with an ensuite bathroom. It was reconfigured to be available for a couple or as a large premium room. Since the last audit this room is now occupied by an existing resident of the facility who moved into this room by choice. At interview the resident confirmed that she chose to</p>

		<p>move into the room to have more privacy and space. She is an avid reader and enjoys the aspect of the room and reduced foot traffic outside her door.</p> <p>Staff members interviewed about the reconfiguration of this double room and the use of the smaller room for rest home level respite talked about being aware of the need to frequently check the residents in these rooms, that some families choose this room because of its location near the old main entrance and nurses station and the additional privacy of its location.</p> <p>The double doors which had previously been in the corridor between the two residents' rooms and the nurses' station have now been removed. When interviewing a group of staff, one staff member who has been at the facility for a year had not noticed the removal of the doors because she had never seen them closed.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in recreational activities. There is a large dining room used by all residents who are able and wish to use it. There are three lounges, one in each wing, which are spacious and enable easy access for residents and staff. Residents can access additional internal recreational areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry by family members if requested. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The annual residents survey had a 100% score for domestic service. This element included questions about care taken with the resident's laundry, cleanliness of their bedroom and the bathrooms.</p> <p>There is a designated house-keeping team who have received appropriate training. These staff attend all relevant internal training and the generic orientation as confirmed in interview of cleaning staff and review of training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaners' trolleys were kept under observation when in use and stored in the laundry when not in use. All cleaning products are removed and stored securely when the trolley is not in use.</p> <p>Cleaning and laundry processes are monitored through each staff member's own practice and a specific internal audit in the annual internal audit programme.</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>HLL has a template and guidelines for emergency planning, preparation and response. These have been used to developed a specific plan for Roseneath and is available and known to staff. The Emergency Plan is based on disaster and civil defence planning guides. The plan describes the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly and was sighted during the audit. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Information and fire evacuation plans are on display throughout the facility.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, consumables and a gas BBQ were sighted and meet the requirements for the facility at full occupancy. Water storage tanks are located around the complex. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. This was also observed during the days of the audit.</p> <p>Appropriate security arrangements are in place throughout the facility. The dementia unit has secure external areas , with key pad access on the internal doors. Doors and windows are locked at a predetermined time and night staff check the doors during their shift.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and views of the grounds and mature established trees. Heating is provided by wall mounted electric heaters in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical manager, operations manager and head office, and tabled at the quality committee meeting. This committee includes the clinical manager, IPC coordinator, the health</p>

		<p>and safety officer, and representatives from care 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 responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for one year. She has undertaken external study in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, and the GP as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support 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 infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in May 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. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a spike in urinary tract infections in January.</p>

		Education with residents is generally on a one-to-one basis and has included reminders about handwashing.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and individually analysed to identify any causative factors and required actions, but does not include system analyses (refer criterion 1.2.3.6). Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>HLL policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator was on leave during the audit but was interviewed by telephone. Another RN was also interviewed. The restraint coordinator's role includes providing support and oversight for enabler and restraint management in the facility and during interview she demonstrated an understanding of the organisation's policies, procedures and practice, and her role and responsibilities.</p> <p>On the day of audit, four residents were using restraints and there were no enablers in use. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with the two RNs.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing</p>	FA	<p>The restraint approval group, made up of the restraint coordinator and two other RNs, are responsible for the approval of the use of restraints and the restraint processes. The approval group meets during the quality committee meetings.</p> <p>It was evident from review of restraint approval group meeting minutes, residents' files and staff interviews, that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored.</p> <p>Evidence of family / EPOA involvement in the decision making was on file in each case. Use of a</p>

<p>education on restraint use and this process is made known to service providers and others.</p>		<p>restraint is part of the plan of care for each of the four residents' files reviewed.</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 were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/EPOA. Both the RN and the restraint coordinator interviewed described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint.</p> <p>The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint and the restraint coordinator's file.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the restraint coordinator and the second RN described how alternatives to restraints were discussed with staff and family members before implementing restraints.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. All processes to ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. There was evidence of families being involved in the evaluation process and their satisfaction with the use of restraint to maintain the safety of their relative.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation</p>

		<p>completed as required.</p> <p>At interview with the restraint coordinator and second RN, both discussed the focus on minimising the use of restraint, and there was evidence of this on the register in relation to a resident who now no longer requires the use of a restraint. Documents on this resident's file demonstrated that the restraint use was appropriate and the approval group considered removal as soon as the nursing care team recommended that it was no longer required.</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 approval group and quality committee undertake a six-monthly review of all restraint use which includes the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meeting reviewed confirmed that the HLL system is implemented. This includes whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families.</p> <p>A summary only of the amount and type of restraint use in the facility, rather than the required analysis of the data is being prepared and discussed. A finding against standard 1.2.3 has been raised in relation to this.</p> <p>HLL's national support office has recently completed an internal audit of the restraint and enabler use at the facility. This has informed recent improvements in the documentation and meeting records. Any changes to policies, guidelines, education and processes are forwarded to HLL support office for consideration. Documents reviewed, minutes and interviews with the two staff members confirmed that the use of restraint is minimised on an individual basis (as noted).</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	<p>HLL has systems and processes for the collection, analysis and evaluation of quality improvement data. There is consistent reporting of adverse events, collection of data and summaries of the types of events are discussed regularly at general staff meetings, the quality committee and nursing staff meetings. Staff members reported receiving these summaries of adverse events and discussing individual responses.</p> <p>The restraint approval group meeting minutes record regular meetings, and list use of restraint by individual residents. Infection surveillance is limited to a description of the type of infections which are occurring each month.</p> <p>There is very limited analysis of summarised data which usually comprises a description of</p>	<p>There is no evaluation or analysis of the collected data to establish if there are trends. Data is only summarised on a monthly basis so there no opportunity to look for any issues which are arising over longer periods of time or for systemic issues to be addressed.</p> <p>In relation to the use of restraints and enablers, the six monthly quality review of restraint use does not analyse the overall use of restraints in the facility. Rather a summary of use by individual residents is discussed and a focus on minimisation is only at the individual resident level. In relation to infection prevention and control, there is similarly a lack of analysis of the summarised infection surveillance data.</p>	<p>HLL has processes for analysing quality improvement data and these need to be utilised so that there is effective evaluation of all information to identify trends and manage any shortfalls in service delivery.</p> <p>60 days</p>

		the events / data which have occurred over the past month.		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>An initial social history and assessment is completed and an activity programme is provided that reflects resident's interests. An individual activity plan is developed and signed off by a DT in the hospital and rest wings. Residents' 24 hour activity plan in the dementia wing was not completed by the DT or activities person and does not reflect activities over a 24 hour period.</p>	<p>The 24 hour activity plan for each resident in the dementia wing is not completed by the recreation officer or DT. Time sections, particularly overnight, are not all completed to include activities for staff about a range of suitable activities that they could undertake with residents at indicated times, when the recreation officer is not present.</p> <p>The sections during daytime include cares, meals and other caregiving tasks. During the night time the sections have either been left blank or include the words "sleeping when checked". Evidence in files reviewed showed that these residents were consistently up / awake during these times.</p>	<p>The 24 hour activity plan for residents in the dementia wing is to include activities over a 24 hour period including during night times when the resident is awake.</p> <p>90 days</p>

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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	CI	<p>The organisation has fully implemented electronic software for medication management, including weekly audit reports that identifies gaps in completing documentation, including reasons for PRN (as required) medication. On review of the weekly audit the facility has implemented training, placed notices and reminders to staff to complete reasons and outcomes of PRN medications administration within the system.</p> <p>A further review of the weekly audits has identified a reduction in the number of non-reporting of outcomes of PRN medication over a two month period. As well this has resulted in an improved outcome for one resident who had poor mobility and a PI in the dementia wing who was unable to verbalise pain. The reason for the PRN medication and a comment as to the outcome was included in the electronic review, and this then resulted in an increase in frequency and a change to pain medication from PRN to regular and more frequent. The resident can now mobilise without assistance and the PI has shown improvement.</p>	<p>Full implementation of an electronic medication system, including weekly audits and reviews to identify reasons and outcomes of PRN medication has resulted in an improved outcome in pain control and PI for one resident.</p>

End of the report.