

# Bosnyak Lifecare Management Limited - Regency Home and Hospital

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## 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 Health Audit (NZ) 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:

<b>Legal entity:</b>	Bosnyak Lifecare Management Limited
<b>Premises audited:</b>	Regency Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 29 June 2017    End date: 30 May 2017
<b>Proposed changes to current services (if any):</b>	none
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	70



# Executive summary of the audit

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## 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

Regency Home and Hospital provides rest home, specialist secure dementia care and hospital level of care for up to 92 residents. A strength of the service includes the activities programme. Residents and family/whānau reported satisfaction with the overall care and services at Regency Home and Hospital.

A full 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 the onsite audit and the review of documentation, observations and interviews. Interviews were conducted with the management, clinical and non-clinical staff, residents, family/whanau and a general practitioner.

There are no required improvements identified at this audit.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and their family/whānau are informed of their rights at admission and throughout their stay. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.

Residents and family/whānau receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure they receive services that respect their individual values and beliefs.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence was seen of informed consent and open disclosure in residents' files reviewed. The advocacy service visits every six months for staff education and attendance at residents' meetings. All staff interviewed understood residents' rights.

The service has an easy to use complaints management system. There is a complaint register that contains any complaint received and actions taken to address any shortfalls

## 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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Organisational structures and processes are monitored at the management and board levels. Service performance is aligned with the recognised business excellence frameworks, the organisation's philosophy and goals identified in the quality and risk plan.

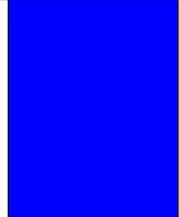
Regency Home and Hospital has a robust documented and implemented quality and risk management system that supports the provision of clinical care and support. The manager is a suitably qualified and experienced enrolled nurse. The manager reports to the owners. The manager is also supported by the clinical nurse leader, who is a registered nurse.

Policies are reviewed by the management team annually and quality and risk performance is reported through meetings at the facility and monitored by the management team. Review of service delivery includes incidents/accidents, infections, complaints and reports from the internal audit programme.

The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Systems for human resources management are established. There are adequate staff numbers each shift to meet the residents needs at the various level of care. The education programme for all staff is available and planned for the year. Staff education is encouraged.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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The registered nurses are responsible for the development of care plans with input from the residents, staff and family member representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

Planned activities are appropriate to the residents assessed needs and abilities and have gained a continuous improvement rating. The activities are varied compared to previous years resulting in record attendances, stimulating interest and promoting physical

activity reducing falls and boredom in the process. Residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management system in place and medicines are administered by staff with current medication competencies. All medicines are reviewed by the general practitioner (GP) every three months and whenever necessary.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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All building and plant complies with legislation with a current building warrant of fitness displayed. Ongoing maintenance ensures the building is maintained to meet the needs of the residents. Fixtures, fittings, floor and wall surfaces are made of acceptable materials for this environment. All rooms have access to hand basins. The rest home wing has full ensuite facilities for all the rooms. There are adequate toilets, showers, and bathing facilities located throughout the facility that provide adequate privacy.

The environment is appropriate for rest home/hospital and specialist dementia level of care services. All areas ensure physical privacy is maintained and have adequate space and amenities to facilitate independence.

There are processes in place to protect residents, visitors, and staff from exposure to waste and infectious or hazardous substances, and to provide safe and hygienic cleaning and laundry services.

The facility has an appropriate call system installed. There is easy access to external gardens, grounds and court yards for residents and their visitors. The physical environment minimises the risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents. The secure dementia unit is separated from the rest home/hospital sections.

Routine safety checks and internal audits are performed by maintenance personal and management. Emergency preparedness was evident with adequate resources being available in the event of an emergency. Staff are trained appropriately in all aspects of health and safety in the work place.

## 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.
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There is a designated restraint coordinator and restraint committee. The use of restraint is minimised and there were 14 residents using a restraint at the time of the audit. Enablers are used on a voluntary basis. All restraint and enabler use is assessed, approved and monitored. Staff receive sufficient education and maintain their competencies. Policies and procedures on restraint and enabler use are current.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Documentation evidenced that relevant infection control education is provided to staff. Infection data is collated monthly, analysed and reported

during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

## 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)
<b>Standards</b>	1	49	0	0	0	0	0
<b>Criteria</b>	1	100	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme. Residents' rights are upheld by staff. For example, staff knocking on residents' doors prior to entering their rooms, staff speak to residents with respect and dignity, with staff calling residents by their preferred names. Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents interviewed reported that they are treated with respect and understand their rights. The family/whānau reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. 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, with the advocate visiting the service to provide information to residents/families and staff. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Residents and family/whānau 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. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints register and sample of complaints evidences that complaints are managed within time frames of Right 10 of the Code. Complaints forms are available at the entrance, with information given on the complaints process as part of the admission procedure and advocacy session with residents and family/whānau. The staff complete a complaints management self-directed work book within three months of employment. Residents and family/whānau report they are encouraged to provide feedback or make a complaint.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their family/whānau (as confirmed by interview with the manager). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (e.g., with the resident in their room). Education is held by the Nationwide Health and Disability Advocacy Service annually.</p> <p>Residents are addressed in a respectful manner and by their preferred names as was confirmed in interview with residents.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p>	<p>FA</p>	<p>The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents' related information. The process for accessing personal health information is detailed.</p>

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		Evidence is seen in files reviewed of the residents' goals which are personalised and reviewed every six months. Staff interviewed report knowledge of residents' rights and understand dignity and respect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The policy on Māori values and beliefs includes guidance for staff on the provision of culturally appropriate care to residents who identify as Maori. A commitment to the Treaty of Waitangi is included. Family/whānau input and involvement in service delivery/decision making is sought if applicable.  There were residents who identified as Māori at the time of audit. The file of one of the residents identifying their specific aspects of their culture that are important to them included a Māori health plan.  Staff education is conducted on the Treaty of Waitangi and staff interviewed reported an understanding of their obligations under the Treaty of Waitangi and respect resident's cultural values and beliefs.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans sampled. The resident satisfaction survey confirmed that individual needs are being met. Staff demonstrated knowledge of acknowledging and respecting each resident's individual culture, values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The employment position description and the Code of Rights define residents' rights relating to discrimination. Staff interviewed verbalise they would report any inappropriate behaviour to the manager, clinical leader or registered nurse (RN). The manager reported she would take formal action as part of the disciplinary procedure if there was an employee breach of conduct. There was no evidence of any behaviour that required reporting and interviews with residents and family/whānau indicated no concerns.
Standard 1.1.8: Good Practice Consumers receive services of an	FA	The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care

appropriate standard.		<p>team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. There is specific training and education to assist the staff working with residents living with cognitive impairment, dementia and minimising challenging behaviours. The activities programme evidences good practice for residents in the rest home/hospital and dementia unit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular or 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 the use of family members and communication cards for the residents who do not speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Regency Home and Hospital is a continuing care facility, providing rest home, hospital and dementia level of care. At the time of audit there were 12 residents living in the dementia unit, 31 residents at rest home level care (including two respite residents) and 27 hospital level of care (including one younger resident under the age of 65). The services are staffed and resourced to meet the needs of the residents at the different levels of care.</p> <p>The mission, vision, values, philosophy and purpose are clearly documented in the business plan and the directors vision statement. The business plan is reviewed annually by the director/owner annually. The business plan focus includes goals and projects for the year in the environment and well as longer term future developments. The ongoing monitoring of performance is conducted through a monthly managers report/meeting with the director. There is also ongoing informal monitoring by the director and facility manager through daily communications.</p> <p>The service is managed by a suitably qualified and experienced manager who is an enrolled nurse (current practicing certificate sighted). The manager has worked at the service for 23 non-consecutive years, with 15 years' management experience. The manager has the responsibility for the overall management of the service and reports to the director. The manager works in close</p>

		<p>liaison with the clinical leader (RN) and administration staff. The manager's job description outlines their role and responsibilities for the management of the service. The manager has attended over eight hours' education related to the management of aged care services, their responsibilities to provide aged care services with the DHB and they attend other clinical education related to dementia and aged care. The manager also receives regular updates from an aged care association regarding management and aged care related topics/issues.</p> <p>The residents and family/whanau interviewed and satisfaction surveys report satisfaction with the quality of care and services provided at Regency Home and Hospital.</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>The clinical leader (registered nurse) takes on the management roles when the manager is on leave. The manager reports confidence in the management team to take on the manager's role during their temporary absence.</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>	FA	<p>Regency Home and Hospital has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular satisfaction survey and monitoring of clinical incidents including infections. The staff interviewed were aware of the quality and risk management system. Outcomes and minutes of the quality committee are available to all the staff. Results of internal audits and analysis of quality data is graphed and displayed in the staff room. Staff reported their involvement in quality and risk management activities through audit activities. Monthly staff and management meetings have trended data and benchmarking results are presented as part of the standing agenda. Meetings are used to review corrective actions put in place.</p> <p>Meeting minutes sampled confirmed monthly review and analysis of quality indicators, such as falls, incidents/accidents and infection surveillance data, and any related information is reported and discussed at the quality and staff meetings. Issues and concerns are reported through the report to the director. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI assessment tool and process and pressure injury management. Policies are based on best practice and the policies sampled are current and up to date. The document control system ensures a systematic and regular review process, referencing of relevant</p>

		<p>sources, approval, distribution and removal of obsolete documents. The policies that are due for review are discussed at the staff and quality meetings. Staff sign to say they have read and understand any updated or new policy.</p> <p>The 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. Regency Home and Hospital has an up to date risk register and quality and risk plan which identifies actual and potential risks for all levels of service. Minimisation strategies have been put in place as required.</p> <p>Staff education includes risk management processes. Interviews with caregivers confirmed their awareness and knowledge of identifying and reporting hazards. The information related to potential hazards are set out in the information book given to all residents and family/whānau members (such as when the carpet was being replaced).</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The management team and staff understand their responsibilities related to mandatory reporting and essential notifications. This includes responsibilities related to reporting of pressure injuries stage three and above. The manager reports that there have been two reportable events (pressure injury and coroner's inquest).</p> <p>The numbers of incidents are collated monthly. Samples of incident/accident forms and the trended data were reviewed. Any trends identified are notified and information fed back to the board, committee meetings, staff meetings and the coaching and mentoring sessions. The service identifies strategies put in place in response to incidents and accidents and these were documented on the actual individual incident forms and on the resident's care plan as required.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<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.</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 three-months and annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Staff working in the dementia care area have completed the required education. The diversional</p>

		therapists have specific education and experience in dementia care. There are three 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.
<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>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. The facility adjusts staffing levels to meet the changing needs of residents. The care staff in the rest home, hospital and dementia unit exceed the minimum contractual requirements.</p> <p>The manager (EN) and clinical leader (RN) are on duty Monday to Friday, and on call at other times. There is at least one staff member on duty with a current first aid qualification each shift. There are two RNs on duty in the rest home and hospital sections on morning and afternoon shifts., and one RN on duty for night shift. The RNs provide coverage to the dementia unit.</p> <p>In the dementia unit, there is at least two caregivers on duty during the morning and afternoon shifts and one during the night. At night, there are four care staff on duty, which allows for the staff member in the dementia unit to call for assistance if required.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. In addition to the care staff, there are sufficient management, activities and support staff to meet the needs of the residents and facility up keep. Residents and family/whānau report satisfaction with the quality, skill and numbers of staff available.</p> <p>Observations and review of six roster cycles confirmed adequate staff cover has been provided, with staff replaced in any planned and unplanned absence.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files reviewed identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses' station and is not accessible or observable to the public. Electronic records are secured and password protected. Entries into the progress notes are made each shift which records the staff member's name and designation. The residents' files reviewed evidence that all records pertaining to individual residents are integrated. The service uses a mix of electronic and paper based records, with the relevant electronic assessment/care plans printed and a copy placed in the resident's hard copy folder. Hard copy records are stored on site and there is electronic archiving and back up for the electronic records. All residents' files reviewed showed evidence of completed interRAI assessments.</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>The entry to service policy includes all the required components on the management of enquiries and entry. Regency Home and Hospital's welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice and where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and are signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Relatives interviewed confirmed that they received sufficient information regarding the services to be provided.</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>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident's records to attest to this.</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 medicine management system is implemented to ensure that residents receive medicines in a secure and timely manner and medicine charts sampled complied with legislation, protocols and guidelines. Medicines were stored safely and securely in the treatment rooms and locked cupboards. Medicine reconciliation is conducted by the RNs when the resident is transferred back to the service. The organisation uses pre-packed medicine packets which are checked by RNs on delivery. All medicines are reviewed every three months and as required by the GP. Allergies are clearly indicated and photos are available to assist with identification.</p> <p>An annual medicine competency is completed for all staff administering medicines and training records were sighted. The RNs were observed administering medicines correctly in the two respective wings. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted and all medicines are stored appropriately. There were no expired or unwanted medicines. Expired medicines are returned to the pharmacy in a timely manner. There was one resident who was self-administering their medicines at the time of the audit. This resident had been assessed as competent to do so and their medicines were stored in a secure safe place. A self-administration policy and procedure is in place.</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>Meal services are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents have a nutritional information plan developed on admission which identifies dietary requirements, likes and dislikes. The resident's weight is monitored regularly and supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</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>The clinical leader and administrator reported that all consumers who are declined entry are recorded on the pre-enquiry form and when a resident is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the resident will be admitted to the appropriate service provider.</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>The initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks per policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews residents and relatives expressed satisfaction with 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 are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate lifestyle care plans and short term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled are integrated and included input from the multidisciplinary team. The residents and family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</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>	FA	<p>The documented interventions in short term care plans and lifestyle care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed also by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies are observed and the staff confirmed they have access to the supplies and products they need.</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>	CI	<p>The activities programme has gained a continuous improvement rating. The activities provided are individualised to be meaningful for people living with dementia, under 65, rest home and hospital level of care.</p> <p>The residents were observed to be participating in meaningful activities on the audit days. Residents were observed to be going offsite with family/friends, with several community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident's lifestyle care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Relatives and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.</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>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The cleaning, laundry and sluice room have safe, secure and appropriate storage of waste, chemicals and hazardous substances. Personal protective equipment (PPE), such as gloves, disposable gowns, sleeves and eye protection is available in the laundry/chemical storage area. The cleaning and laundry staff demonstrated knowledge on the safe use of the chemicals and PPE. Staff have ongoing education on infection prevention and control and the use of chemicals.</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>The service has a current building warrant of fitness displayed.</p> <p>Hot water temperatures are monitored with the recordings within safe guidelines. Medical equipment has had annual calibration and electrical equipment is test and tagged. There has been a monthly compliance check of the environment. There is an ongoing maintenance schedule for refurbishment and replacement of carpeting and furnishing. This has commenced at the time of audit.</p> <p>The environment promotes safe mobility, with secure hand rails in the hallways and floor surfaces that are intact and do not present a trip hazard. Each wing has access to the external areas. The dementia unit external area is separated from the rest home/hospital sections of the service. There is covered seating areas off each of the wings.</p> <p>The residents and family/whānau reported satisfaction 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>The rest home wing has full ensuite facilities for all rooms. The rest of the wings have adequate numbers of shower, bathing and toilet facilities. There are at least four toilets and three showers (for maximum of 30 residents). In the dementia unit, there are two shared showers and toilets and three rooms with full ensuite facilities. The shared facilities are designed for disability access. All the shared facilities have privacy locks and signage. The residents and family/whānau reported satisfaction with the facilities at the service.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>All rooms are single occupancy and suited to the needs of residents requiring rest home, hospital or dementia level of care. The rest home/hospital wings are separated from the specialist dementia unit. Each resident's room has their personal items and provides enough space for the resident and staff to mobilise. The residents and family/whānau reported satisfaction with the personal space and</p>

adequate personal space/bed areas appropriate to the consumer group and setting.		the individualised care that meets the resident's needs.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a central dining area in the rest home, with smaller dining areas located in each of the wings. There are four lounge areas that provide sufficient space for entertainment and recreational activities. The dementia unit is separated from the rest home/hospital wings. Residents' rooms also provide areas for residents to relax or entertain in privacy. The residents and family/whānau reported satisfaction with the access to dining and lounge facilities</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>The cleaning and laundry is conducted by specific cleaning and housekeeping staff. The linen laundering is conducted by an offsite laundry service, the resident's personal laundry is washed onsite. The laundry has a dirty to clean flow, with processes implemented for infection prevention and control. Chemicals, laundry and cleaning equipment are securely and hygienically stored. The external chemical supplier conducts monthly reports on the effectiveness of the cleaning and laundry chemicals.</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>	FA	<p>The approved evacuation scheme is dated July 2004. There have been amendments required since the plan was approved.</p> <p>The fire and emergency equipment has a monthly inspection as well as an annual certification by an external contractor. Emergency and security training is provided as part of staff orientation and ongoing in-service education. Evacuation drills are conducted six monthly, with the most recent conducted in March 2017. Staff demonstrated knowledge on how to respond in emergency or civil defence situations.</p> <p>The service has bottled gas for cooking and emergency lighting in the event of mains failure. There is bottled drinking water and other water in tanks that is accessible in emergency situations.</p> <p>Each room, toilet and bathing facility has access to a call bell. The call bell system has a pager/locater system, in which staff are alerted to when a call bell is activated. There was a fault in the call bell in one room at the time of audit (call taking time to register on the pager/locater), with this rectified at the time of audit. The residents and family/whānau reported satisfaction with the time frames in which call bells are answered.</p> <p>The layout of the dementia unit allows for residents with cognitive impairment to wander freely</p>

		<p>inside and into the two secured external areas.</p> <p>There are processes and checklists conducted to ensure the entrances, doors and windows are secure. There is an additional contracted security service at night. Staff, residents and family/whānau reported satisfaction with the security arrangements.</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 areas used by residents and family/whānau are ventilated and heated. Each resident's room, ensuite and hallway have at least one window. There is a mix of wall mounted heating in the dementia unit, hospital and hallways. The rest home has freestanding heaters. The residents and families reported satisfaction with the heating, light and ventilation.</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>Regency Home and Hospital provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The RN is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</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</p>	FA	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p>

the organisation.		
<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 organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and could locate policies and procedures.</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>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint minimisation policy. This includes methods for minimising restraint and approved alternatives. The assessment, approval, monitoring and review process is the same for both restraints and enablers.</p> <p>Regency Home and Hospital aim to minimise the use of restraint through completing falls risk assessment forms, use of call bell system, restraint monitoring forms and engaging the residents</p>

		<p>who are at risk of absconding in various activities. An updated restraint register was sighted and staff interviewed understood the difference between a restraint and enablers. Risk minimisation was documented in the care plans of the residents and restraint was evaluated regularly. The family and residents are fully informed about the restraint process and risks involved. Definitions of restraint and enablers are consistent with this standard. Records sampled attest that staff work to minimise the use of restraint. Goals for minimising the use of restraint are discussed at staff and quality management team meetings.</p> <p>All staff complete a restraint minimisation competency during orientation and prior to each restraint training and this includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation and review process.</p> <p>There are currently 14 residents using restraint and these include bedrails and vests.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The clinical leader is the designated restraint coordinator and is responsible for education of staff ensuring the restraint process is followed per policy and procedure. The roles and responsibilities of the restraint coordinator are clearly defined and there are clear lines of accountability. The approval process is in place and included the Clinical leader, GP, resident and family member. Restraint use is discussed in management and staff meetings. Approved equipment which can be used as a restraint includes low beds, bed rails, lap belts, vests and brief restraint.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint co-ordinator completes restraint assessment forms for residents who demonstrate that the use of restraint may be indicated. There was evidence in the files of the resident on restraint and risk factors were identified in the assessments and the purpose of the chosen restraint was clearly documented. The implementation of restraint for the resident is linked to the care plan. Interviewed staff members demonstrated understanding in maintaining culturally safe practice. Consent for the use of restraint was provided by the GP, co-ordinator and family/whanau.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>A current updated register was sighted. The lifestyle care plans have documented risk management plans required to ensure the resident's safety while restrained. The service has an approval process as part of the restraint minimisation policies and procedures that is applicable to the service and</p>

		<p>accessible to staff to read. Restraint authorisation is in consultation with resident, family/whanau, restraint co-ordinator and GP. The approval process ensures the environment is appropriate and safe. Restraint use is reviewed at least three monthly and six monthly and as part of restraint register reviews. Staff interviewed demonstrated understanding about restraints and strategies to promote safe practice.</p> <p>The restraint monitoring and observation process is included in the restraint policy. There were no restraint related injuries reported.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Regular reviews are conducted on residents and this was evident in the records sampled. GP confirmed involvement in the restraint review process. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring and any change required. Interviewed staff and family/whanau confirmed involvement in restraint use. The evaluation forms included the effectiveness of the restraint in use and the risk management plans documentation in the lifestyle care plans. Evaluation time frames are determined by the risk levels.</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>	FA	<p>The service has demonstrated monitoring and quality review on the use of restraint. Restraint updates are included in the monthly staff and periodic quality control meetings. Individual approved restraints are completed three to six monthly through restraint meetings and as part of the facility approval team review with family/whanau involvement. Meeting minutes confirmed discussions on restraint are being conducted and included review of restraint use. The clinical leader reported that assessments and monitoring are appropriate. Policies and procedures are up to date with training records sighted and annual reviews undertaken.</p>

## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>There is a full range of social activities that are available on the weekly programme for all residents to participate in. Residents who have dementia, under 65 years of age, rest home and hospital level of care are assessed and invited to specific activities that are appropriate for their level of ability and these are used to facilitate emotional and physical wellbeing. The activities can either be group activities or one on one under the guidance of the DT and activities coordinator. All the activities evidenced documented evaluations on the resident's participation and the outcomes that residents are achieving from these. Through the evaluation of existing activities, the service has implemented further stimulating activities to gauge interest and capture those still reluctant to join in. The service provides a documented evaluation and self-assessment of the whole programme as part of maintaining ongoing compliance with evidencing that the service is a centre of excellence for the implementation of the robust activities programme. The activities are varied and unique when compared to previous years resulting in record high attendances, stimulating interest and promoting physical activity thereby reducing falls</p>	<p>The achievement of the quality improvement projects in the activities programmes and implementation of the programme is rated beyond the expected full attainment. With these projects, there has been a documented review process which includes the analysis and reporting of findings. The introducing of new club activities and the evaluation of existing clubs include documenting actions to make improvements in the activities programme. With this there has been increased staff knowledge, and confidence and skill in resident self-work and developing and increasing resident's skills and participation in meaningful activities. Positive outcomes have been measured in staff, resident and relative</p>

		and boredom in the process.	satisfaction.
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End of the report.