# Heritage Lifecare (BPA) Limited - Maidstone Hospital

## Introduction

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

The audit has been conducted by 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Heritage Lifecare (BPA) Limited

**Premises audited:** Maidstone Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 15 February 2018 End date: 16 February 2018

**Proposed changes to current services (if any):** A sale and purchase agreement to a new provider

**Total beds occupied across all premises included in the audit on the first day of the audit:** 27

# 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.

## General overview of the audit

Maidstone Hospital provides rest home and hospital level care for up to 32 residents. The service is operated by BUPA and managed by a care home manager and a clinical manager. Residents and families spoke positively about the care provided.

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

This facility is being sold and this provisional audit is being undertaken to establish the prospective owner’s preparedness to provide a health and disability service and the current level of conformity with the required standards. A sale and purchase agreement with the prospective provider, Heritage Life Limited, is anticipated to be enacted in April 2018.

This audit has resulted in identified areas requiring improvements relating to human resources and kitchen, food temperature recordings.

## Consumer rights

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. A comprehensive Māori health plan and related policies guide care. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

There is a complaints process that is understood by residents, family members and staff and meets the requirements of the Code of Health and Disability Services Consumers’ Rights. The manager maintains a current complaints register.

## Organisational management

Business and quality and risk management plans include 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 and analysis of quality improvement data, identifies trends and leads to improvements. 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 were current and reviewed regularly.

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

A resident information management system is in place and information is entered in a timely and accurate manner. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

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## Continuum of service delivery

The organisation works closely with the local Needs Assessment and Service Co-ordination Service (NASC), to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission, within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff and designated general practitioners. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents’ files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a trained diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and senior care staff, all of whom have been assessed as competent to do so.

The food service is prepared and delivered on site and meets the nutritional needs of the residents with special needs catered for. Policies and procedures guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised and clean. Choices are available and residents nutritional need are identified, documented and provided for. Residents and their family/whanau verified satisfaction with meals.

## Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is 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 offsite 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

The organisation has implemented policies and procedures that support the minimisation of restraint. Two enablers were in use at the time of audit. No restraints were in use. 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

The infection prevention and control programme, led by an appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice is accessed from the district health board (DHB), microbiologist, infectious diseases physician, and group clinical advisory committee. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education. Aged care specific infection surveillance is undertaken, analysed, trended, 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 | 43 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 2 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Maidstone Hospital 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 to residents and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Registered nurses and care staff interviewed understand the principles and practice of informed consent and have received education on induction and as part of the annual education plan. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, visits from the GP and outings. Individual consent forms were cited for van trips, vaccination, and valuables.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s record. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day to day care on an ongoing basis.  Residents and family/whanau interviewed were able to give examples of when verbal and written consent was obtained. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Residents and family/whanau interviewed were given an information pack on admission which included the Code of Rights and a pamphlet on the advocacy service. They were aware of the Advocacy Service, how to access this and their right to have a support person if required. None of the residents/ family/whanau have had to access this service. Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed at staff interviews. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | 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 supports the philosophy of Quality of Life, caring and living life to the highest level of independence.  The facility has unrestricted visiting hours and encourages visits from residents’ family/whanau and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff, they could stay as long as they required, attend social events and could have family gatherings at the facility. They were encouraged to have continuing involvement in the day to day care, were invited to dine with their family member, attend the church services, take their family member on outings, join in on outings that the facility provided, for example barbeques, and recently celebrating Valentine’s Day with their husband/wife. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints/concerns/issues policy and associated forms 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.  The complaints register reviewed showed that two 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 any required follow up and improvements have been made where possible. One complaint was a Health and Disability Commissioner (HDC) complaint and this has been resolved. The care home manager (CHM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service) through the care home manager and clinical manager as part of admission process, information provided, to resident and family/whanau, and discussions with staff. The Code is displayed in a visible location at the entrance way to the rest home and hospital.  New Provider Interview January 2018:  The prospective provider is an experienced aged care sector provider. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the requirements of the Code as part of their existing roles. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  The service ensures that the residents’ rights to privacy and dignity are recognised and respected at all times. Staff understood the need to maintain privacy and were observed doing so throughout the audit while attending to personal cares, knocking on residents’ doors prior to entering rooms, exchanging verbal information privately with residents and their family/whanau. All residents have a private room and the residents’ personal belongings were observed to be decorating their personal space such as pictures, framed photographs, their own chairs, rugs, individual framed maps of their lives.  Residents are encouraged to maintain their independence by staff ensuring individual care plans are followed, residents are encouraged to attend community activities, participation in clubs of their choosing, having family gatherings for birthdays and anniversaries in a private lounge on site. Family/whanau are encouraged to have meals with their family member and attend activities and residents’ meetings to give feedback as confirmed in interviews with family members. Each plan included documentation related to the resident’s abilities, and strategies to maximise independence. Residents’ information is held securely and privately.  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.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records. Interviews with residents and family/whanau confirmed they had not witnessed any abuse or neglect while in the facility. |
| 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 | 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 whanau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Staff receive education on cultural awareness during orientation to the service and at in-service training. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. On the days of audit there were no residents who identified as Maori in residence. |
| 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 respect these. Resident’s personal preferences, required interventions and any special requirements are identified on admission. Cultural values, beliefs, social and recreational needs were included in all care plans reviewed. Residents had dietary preferences and spiritual preferences documented, and interviews with residents and there family/whanau confirmed that staff ensure the residents’ needs are met. A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met and this supports that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner interviewed also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet, their individual employment contract and job descriptions. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, physiotherapist who visits weekly, occupational therapist, social workers, support persons, wound care nurse specialists, community dieticians, a psycho-geriatrician, mental health services for older persons and links with the local community.  Registered nurses are rostered on every shift and were observed promoting, advising and encouraging best practice with the caregivers on duty. There is regular in-service training for staff and external programmes available. The GPs review stable residents every three months and more frequently as required. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required, staff were responsive to medical requests and treatment plans. The GP interviewed is also available by cell phone and text messaging ensuring he is available in a timely way for advice if any changes occur with residents.  Staff reported they receive management support for internal and external education through Careerforce training and there is evidence of a compulsory plan for all staff where staff are booked to attend education to support contemporary good practice.  Caregivers document in residents’ clinical notes every shift with their name and designation stamp, this is countersigned by the RN on duty with name designation and registration stamp. This system provides clarity and accountability around who is responsible for every documentation entered in the clinical notes  Other examples of good practice observed during the audit included extra fluid rounds, prompt answering of call bells, regular toileting rounds, and pressure injury prevention strategies where every bed in the facility now has a pressure prevention mattress. There were no pressure injuries in the facility at the time of the audit. Residents and family/whanau interviewed confirmed their needs are promptly met and of an appropriate standard. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family/whanau 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 were involved in outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed where evidence of regular communication with family/whanau was documented. There was also evidence of resident/family/whanau input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  The service has an interpreter policy and a list of contact details of available interpreters. Interpreter services can also be accessed via the DHB or Older Persons Health Service when required. Staff knew how to do so, although reported this was rarely required due to all residents able to speak English. Staff able to provide interpretation as and when needed and the use of family members and communication cards are available for any potential residents for whom English is not their first language. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. A sample of monthly and quarterly reports to the board of directors showed adequate information to monitor performance is reported including occupancy rates, staffing numbers, emerging risks and issues, incidents and accidents, concerns and complaints.  The service is managed by a care home manager (CHM) who holds relevant qualifications and has been in the role for three years, prior to that she has been in management roles in the aged care sector for many years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CHM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through professional development and local sector meetings.  The service holds contracts with the Canterbury DHB for rest home and hospital level care and with ACC for one resident. Twenty-seven residents were receiving services under the contract at the time of audit. There were no respite residents.  New Provider Interview January 2018:  The new provider Heritage Lifecare Ltd (HLL) is an established New Zealand aged care provider, currently operating more than 1100 beds in the sector. This proposed acquisition of Maidstone Hospital, is part of an acquisition programme that will add a further twelve facilities across the country. As of 30 January 2018 HLL has set up a new company to acquire and operate this group of new facilities. This company is Heritage Lifecare (BPA) Ltd. However for ease of reference the new provider is referred to as Heritage Lifecare Limited (HLL) throughout this report. An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017). The national quality manager interviewed reports the intention to increase the management level resource to provide a further operations manager and an additional supporting quality role following the purchase.  The transition plan is led by an experienced and well-qualified project team who are specifically focussing on the integration of the current facilities into the Heritage Lifecare Ltd group. This includes provision of infrastructure support such as providing information technology capability including hardware and software. Regional workshops are planned to introduce documentation, and the new HHL systems and processes. This is planned to occur within the first three months. The project team is working with the BUPA team to ensure a smooth transition of each operation.  It is expected that the senior team and existing staff will remain in place at each facility.  The prospective purchaser has notified the relevant District Health Board prior to the provisional audits being undertaken. |
| Standard 1.2.2: Service Management  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. | FA | When the CHM is absent, the organisation provides locum care home manager cover from within the organisation. During absences of key clinical staff, the clinical management is overseen by one of six other registered nurses who are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.  New Provider Interview January 2018: The prospective provider is not planning any staffing changes. Existing cover arrangements for the day to day operations will remain in place, with access to regional operations managers. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation 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 patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and adverse events.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and attendance at meetings. Relevant corrective actions are developed and implemented to address any shortfalls.  Resident and family satisfaction surveys are completed annually. The most recent survey showed residents would like staff to have more time chatting, more variety in food, more variety in movie nights, that the toilets smell dirty and there was limited wheelchair access to grounds and buildings. The service has implemented changes as a result. Staff have been advised to take time to chat, there has been a change in the cook with improvements noted at residents’ meetings, air fresheners in toilets are now checked twice a day instead of once, and all the external bushes have been cut back and paving replaced in two places.  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.  The CHM 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.  New Provider Interview January 2018: During the transition phase, HLL policies and procedures will be introduced. By the end of 2018, a new software system will be introduced to incorporate risk management including adverse event reporting, care planning and client management. Meanwhile, the electronic BUPA system will be superseded by HHL documentation and will be reliant on hard copies on site until the electronic system is fully implemented. This is anticipated to be within six months of the purchase.  HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure. A key strategy to introduce a national clinical governance group is planned in the next 12 months. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported on the electronic reporting system that is then managed by head office.  The CHM described essential notification reporting requirements, including for pressure injuries. They advised there have been and no notifications of significant events made to the Ministry of Health, DHB since the previous audit.  New Provider Interview January 2018: There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The national quality manager interviewed could verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | 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. However, there is no evidence of police vetting having been completed and this needs improvement. A sample of staff records reviewed confirmed that other policies are being consistently implemented and records retained.  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 showed documentation of completed orientation and a performance review after a three-month period, however annual appraisals are overdue and this requires improvement.  Continuing education is planned on an annual 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. A staff member is the internal assessor for the programme. There are 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. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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 staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-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. The interRAI assessment outcomes are used to guide staffing decisions.  New Provider Interview January 2018:  The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the Guidelines for safe staffing level and indicators. The representative for HLL interviewed could confirm understanding of the required skill mix to ensure rest home and hospital care residents needs are met. The organisation already provides the range of levels of care (geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review.  Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents’ files are held for the required period before being destroyed.  No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | 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/whanau are encouraged to visit the facility prior to admission and meet with the care home manager (CHM) and clinical manager (CM). They are also provided with written information about the service and the admission process, viewed at audit. The service operates a waiting list for entry. The organisation seeks updated information from the NASC and the GPs for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them prior to admission and on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB’s ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, 24 hours of medication, 24 hours of progress notes, wound charts (where applicable), and advance directives are provided for the ongoing management of the resident. A checklist ensures this occurs. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility, showed a planned, co-ordinated transfer to the acute care service and transition back again. Family members of the resident were kept well informed during the transfers of their relative as evidenced in documentation in the family notes. Transfer of a resident to the acute care facility on the second day of audit was also observed to follow transfer processes. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management was observed on the day of audit with the RN wearing an apron, identifying not to be disturbed as medication round in progress. 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 and have completed annual medication competencies and medication education.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription and any pharmacy errors are recorded and fed back to the supplying pharmacy. All medications sighted were within current use by dates. Clinical pharmacist input is provided three monthly and on request.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly, stock on hand and six monthly stock checks and accurate entries. Standing orders are rarely used but processes are in place to enable safe administration and appropriate documentation.  Medications are stored and managed in line with legislation and guidelines and the records of temperatures for the medicine fridge has temperatures recorded daily and are within acceptable ranges. There were no expired medications.  An electronic system is in use, ‘1CHART’, with best practice prescribing noted, including identification of the prescriber and the 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 was consistently recorded on the medicine 1CHART with prompts before the review is due. The pharmacist has access to the system and medicine reconciliation is occurring.  There were no residents self-medicating at the time of audit, but appropriate processes are in place to ensure this is managed in a safe manner, should it be required. Pain assessments were well documented in response to analgesia administered.  Medication errors are reported to the clinical manager, recorded on ‘Riskman’ (an incident reporting system), which alerts the home care manager and quality and risk co-ordinator. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | The food service is provided on site by the kitchen manager and kitchen assistants 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 time have been implemented.  Not all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. Documentation of inwards goods is occurring, however lacks clarity around temperatures recorded on arrival to the facility and when temperatures are above recommended guidelines; there was no evidence of corrective actions. When fridge/freezer temperatures of stored foods were above recommended guidelines there was no evidence of corrective actions taken. Whilst in the kitchen during the audit, temperatures reached 30 and 32 degrees.  The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The kitchen manager is notified of any allergies, dietary changes, weight loss or other dietary requirements. 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 have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident’s nutritional needs, is available and was observed in use.  Evidence of residents’ satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents’ meeting minutes. Residents were observed to be given sufficient time to eat their meal and those requiring assistance had this provided. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC service is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC service is made and a new placement found, in consultation with the resident and family/whanau. Examples of this occurring were discussed with the Clinical Manager. There is a clause in the access agreement related to when a resident’s placement can be terminated |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools such as pressure risk- Braden scale, skin assessment, pain scale, cultural assessment, nutritional screening, falls risk, continence assessment, activity assessment and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents’ files reviewed during the audit had a current interRAI assessment which informed the care plan. Residents/family/whanau confirmed they were involved in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidenced service integration with progress notes, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families/whanau reported participation in the development and ongoing evaluation of care plans.  The guidelines for writing documents stated that residents will have a care plan developed within 24 hours of admission (see standard 1.3.4 for assessment tools). An individual lifestyle plan is developed within three weeks of admission and this was evidenced as occurring in files reviewed.  Short term care plans are developed in response to specific problems and kept on the resident’s file for as long as needed. If the problem continues, it is included in the long term care plan. The guidelines documents include frequency of reviews (See standard 1.3.8).  Clinical staff have annual training in care planning. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard at Maidstone Hospital. The CM, RNs and care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ identified needs, as observed at audit |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is co-ordinated by one trained diversional therapist (DT), who oversees the two activities assistants and between them they provide activities across seven days a week. The activities assistant interviewed has been in her role for two years.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. A Map of Life is also completed on admission with the resident and family/whanau which includes where they were born, where they have lived, what countries they have visited, interests, history of employment, travel, family, and grandchildren. The map of life is framed and placed on the wall in each resident’s room as a cue for conversation that is meaningful to them. Activities assessments which include the resident and their family/whanau members are regularly reviewed to help formulate an activities programme that meets the individual needs and interests of the resident. The resident’s activity needs are evaluated as their needs change, monthly, and as part of the formal six monthly care plan review. The individual activity plan is incorporated into the My Day, My Way care plan, and was reviewed at the same time as the care plan in all residents’ files reviewed.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities, exercise classes and regular events are offered. Examples included musicians playing music and singing, planned outings, individual outings, volunteers coming to read to residents, and children’s groups coming to visit. One on one activities are organised for those who choose not to join the group activities or have special needs. The physiotherapy assistant under takes a mobility/exercise programme with groups and individually on a daily basis as was observed at audit.  The activities programme is discussed at the residents’ meetings, to which family/whanau are also invited. Input is sought and responded to. Resident/family interviews confirmed this is occurring. Residents’ meeting minutes and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered and the programme encourages each resident to reach their highest level of independence within the limitations they have. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for urinary tracts infections (UTIs), falls, infections, any changes in the resident’s normal status, and progress was evaluated as clinically indicated at least weekly and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. All residents have the choice of their own GP. 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 physiotherapist, occupational therapist, needs assessor, gerontology clinical nurse specialist, oncology support service, counselling service, stoma nurse specialist, wound care specialist, geriatrician, and older persons’ mental health services. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required Chemical Handling Approved Handler Training (HSNO). 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.  There is provision and availability of protective clothing and equipment and staff were observed using this. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 01 June 2018) is publicly displayed.  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 maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence is promoted.  External areas are safely maintained and are appropriate to the resident groups and setting. Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required, that any requests are appropriately actioned and that they are happy with the environment.  New Provider Interview January 2018:  HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each facility. There are presently no plans for any environmental changes in the facility. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.  There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities, and to have quiet or private time. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is undertaken off site by a contracted provider. Care 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.  There is a small designated cleaning team who have received appropriate training. These staff have undertaken the organisation’s cleaning programme 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.  Cleaning and laundry processes are monitored through the internal audit programme and externally by the contracted provider. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described 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 on the 09 January 2007. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service; the most recent being on 01 November 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ’s were sighted and meet the requirements for full occupancy of the facility. Water storage tanks are located around the complex. Emergency lighting is regularly tested.  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.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises during the night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by electric panel heaters in residents’ rooms and heat pumps in the communal areas. Areas were comfortable and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  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. | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the clinical co-ordinator/infection prevention and control officer (IPC). The infection control programme and manual are reviewed annually.  The clinical manager/registered nurse, with support from the care home manager, 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 facility care home manager, and tabled at the quality/risk committee meeting. This committee includes the operations manager, care home manager, organisational IPC co-ordinator, clinical manager/IPC coordinator, kitchen manager, activities co-ordinator and the health and safety officer. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff.  Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control (IPC) coordinator has appropriate skills, knowledge and qualifications for the role. The infection control co-ordinators and the care home manager have completed recent training. The care home manger supports the IPC co-ordinators. Well-established local networks with the infection control nurse specialist - Older Persons Health, are available and expert advice from the laboratory is available if additional support/information is required. The IPC coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available and was observed being used by staff. |
| Standard 3.3: Policies and procedures  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. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are reviewed yearly and included appropriate referencing.  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. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection prevention control 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 increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. There has not been an outbreak in the facility in the previous five years.  Education with residents is generally on a one-to-one basis and has included, reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids to prevent urinary tract infections and extra fluids in hot weather. Families confirmed they also were given education by staff that if unwell not to enter the facility. There is a notice at the front entrance giving guidance on this. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the individual infection register in the resident’s clinical record, infection reporting form, and resident management system. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, infection control co-ordinators, home care manager and operations manager. Data until recently has been benchmarked with other aged care providers of a similar size but currently this system is unavailable.  New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | 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 provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her role and responsibilities.  On the day of audit, no residents were using restraints and two residents were using lap belts as enablers, which were the least restrictive and used voluntarily at their request. All documentation was current and completed.  New Provider Interview January 2018: HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for use of enablers. These policies are implemented across the group and a small number of restraint devices are approved for use following assessment. The prospective provider is experienced in the requirements of the standard, as it pertains to aged residential care. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Appraisals have not all been completed in 2017. The CHM has implemented a corrective action plan to complete these by the end of March. However, she is leaving in one week following the audit (last day 23 Feb 18), and there are still eleven staff appraisals overdue.  While the CHM reports that police vetting is occurring, the service then removes the results from staff files. There is no documentation included to confirm that the police vetting has been completed. | Eleven performance appraisals are overdue. There is no documentation in staff files to show police vetting has occurred. | Staff have appraisals completed annually. Documentation in staff files shows police vetting has occurred.  90 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The previous five months of temperatures of inwards goods were audited and there were numerous inconsistencies noted of whether goods received were frozen or chilled, for example one entry had both ice cream and cream cheese on the same line and the temperature was recorded as plus 4. There was no evidence of any corrective actions taken when temperatures noted in many entries would have been outside of the recommended range.  The previous three months of fridge/freezer temperature readings were audited, the documentation demonstrated that despite many occasions where temperatures were recorded as above or below recommended guidelines there was no evidence of any corrective actions taken.  Whilst in the kitchen during the kitchen audit process the kitchen felt very hot. The temperature gauge was checked and recording a temperature of 30 degrees and one hour later when rechecked the gauge was reading 32 degrees. The kitchen manager reported that the air cooler is not powerful enough for the size of the room and when it is in operation drips water on the area where staff are working creating a hazard. | In the previous five months monitoring of inward goods was occurring, however the records lack clarity about whether those items with temperatures recorded are frozen or chilled, or whether the temperatures are within recommended guidelines.  There was no evidence of a corrective action when temperature recordings were above recommended guidelines, for example fridge /freezer temperatures.  In the kitchen during the audit it was noticed the temperature reached 30 degrees and an hour later was 32 degrees. The kitchen manager reported that the air cooler is not sufficient for the room and when it is in operation drips water on the area where staff are working creating a hazard. However, this has not been added to the hazard register. | Ensure all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.  60 days |

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

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

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

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

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| No data to display |

End of the report.