

Heritage Lifecare (BPA) Limited - Waterlea Rest Home

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](#).

The specifics of this audit included:

Legal entity: Heritage Lifecare (BPA) Limited

Premises audited: Waterlea Rest Home

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 25 January 2018 End date: 26 January 2018

Proposed changes to current services (if any): Waterlea has been purchased from Bupa by Heritage Lifecare Limited promoting this provisional audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 54

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

Waterlea Rest Home (Waterlea) is a 61 bed aged care facility in Blenheim that provides rest home level care, including for up to 19 people who require dementia level care and support. The service is operated by Bupa New Zealand, although has recently entered into a sale and purchase agreement with Heritage Lifecare Limited, which promoted the need for this provisional audit. A facility manager and a clinical manager are responsible for the management of Waterlea. Residents and their family members spoke positively about the care and support 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 audit has identified three areas requiring improvements relating to the management of hazardous substances, the need for more detailed 24-hour plans for residents in the dementia service and the use of an undocumented personal restraint.

Consumer rights

A poster of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is on display and copies of the brochures given to residents and family members. Staff are provided with education updates on the Code each year. Information on the availability of advocacy services is also provided at the time of admission and thereafter as required.

Residents' rights, as described in the Code, are being upheld. Services provided take into account personal choices and individual needs. People's privacy is respected, as is their dignity, and independence is encouraged. Staff were observed interacting with residents in a respectful manner.

There were no residents who identified as having specific Māori cultural values and beliefs at the time of audit. Templates based for service delivery plans based on the Te Whare Tapa Whā model are available as are contact details of the local marae.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained. Examples of best practice are applauded.

Communication processes between staff, residents and families are transparent, well documented and enable open relationships. Formal interpreter services are accessible, as is assistance for those with communication related disabilities.

The service has strong linkages with a range of specialist health care providers, many of whom visit the facility, and family and friends of residents may come and go as they choose.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

The organisation's scope, direction, goals, values and mission statement are documented and readily available to staff and residents and families. 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 and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

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

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

Care plans are individualised and are based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage new problems that arise. 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.

A diversional therapist plans and implements an activities programme that provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

The food service meets the nutritional needs of the residents with special needs and personal preferences catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen is new, was well organised, clean and meets food safety standards. Residents 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 is well managed and staff understand their roles in maintaining a safe environment. Staff use protective equipment and clothing. Soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

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

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Two enablers were in use at the time of audit. No intentional restraints were in use. Regular reviews of the restraint free environment occur. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the current restraint and enabler processes.

Infection prevention and control

The infection prevention and control programme is led by the clinical manager who was on leave at the time of the audit. A suitably trained relief clinical manager is currently responsible for implementation of the programme, which 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 able to be accessed from the District Health Board, the local public health unit and the GP.

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, with analysis of infections at the individual and collective level occurring. Results are reported through all levels of the organisation and 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	44	0	6	0	0	0
Criteria	0	94	0	6	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Waterlea Rest Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>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. Staff interviewed confirmed their knowledge on the requirements of the Code and observations of their actions during the audit demonstrated that their knowledge is being incorporated into practice.</p> <p>Residents and relatives interviewed, and who understood the Code, confirmed that the principles of the Code are upheld.</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</p>	<p>FA</p>	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies and procedures provide relevant guidance to staff. Organisational informed consent forms have been completed as required for issues such as the</p>

<p>choices and give informed consent.</p>		<p>taking and use of photographs, outings, use of personal information and ongoing care and support. Copies of these were in all of the residents' files reviewed.</p> <p>Copies of documentation to meet enduring power of attorney (EPOA) requirements, advance directives (as applicable) and resuscitation status were in residents' records and the management of consent for people not able to sign for themselves meets requirements. Explanations from the clinical manager demonstrated a good understanding of these situations.</p> <p>Staff were observed to gain verbal consent from residents throughout the day. This was also evident in the 'Forget Me Not' unit regardless of the apparent level of understanding of the person. Residents and family members confirmed that being given options is usual practice and residents stated that they consistently get to make choices about everyday activities such as their bed-time, when and if they want a shower and what activities they wish to participate in, for example.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters with information about the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Residents confirmed that they have or would use family members to advocate for them if this was needed. There was good evidence of family members supporting residents in the dementia service. Examples of people from the Alzheimer's Society pro-actively continuing to support residents in the 'Forget Me Not' unit were reported.</p> <p>Staff receive education from a local advocate, therefore are aware of how to access the Advocacy Service. Examples of situations when the advocacy service has been involved were discussed with the manager, although none were recent.</p> <p>The new provider's policy on resident advocacy provides guidance for</p>

		<p>the facility to identify on admission: the resident's next of kin or EPOA or welfare guardian; whether they have none of these or another person whom they wish to provide assistance or support when needed; and if there is no one identified and the resident is in need of assistance, or requests assistance, they will be provided with Advocacy Network services and the Health and Disability Commissioner contact numbers.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents, including those from the dementia service, are being supported to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. A range of community services, such as the Cancer Society, the Alzheimer's Society and the Stroke Foundation come into the facility to provide individual support for some residents. In addition, community groups such as from the church, local musicians and schools also facilitate links with the local community for residents. Other health service providers such as district nurses and the older persons' mental health service are also involved in the services delivered at Waterlea.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they feel welcome when they visit and are comfortable in their communications with staff.</p> <p>Residents confirmed during interview that staff go to extra lengths to ensure they remain linked with the local community as much as possible and expressed appreciation for staff input in assisting with this.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints and concerns 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.</p> <p>The complaints register reviewed showed that two complaints have been received since June 2017 and that actions taken, through to an</p>

		<p>agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>Information about the Nationwide Health and Disability Advocacy Service (Advocacy Service) is included in the information packages provided when people enquire about the services at Waterlea, as well as on admission. The clinical manager explained that residents and relatives are informed about the Code when new residents are admitted into Waterlea. Residents interviewed reported they were aware of the Code and confirmed that staff discussed these with them on admission.</p> <p>The Code, with information about the Advocacy Service at the bottom, is displayed in both English and te reo Maori in the facility. Copies of the brochures on the Code and the Advocacy Service were sighted in the reception area, along with copies of complaint and feedback forms.</p> <p>The prospective provider is an experienced aged care sector provider, therefore is familiar with the Code. Clinical staff and caregivers 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.</p>
<p>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.</p>	FA	<p>Policy and guidelines on privacy and dignity were available. During interviews with residents and family members they confirmed that services are being provided in a respectful and dignified manner with attention to expectations around privacy and personal preferences. Staff were observed to address residents with respect and this was also evident in the dementia service. Residents were observed being encouraged to be independent and given choices including in the</p>

		<p>dementia service wing, otherwise referred to as 'Forget Me Not'. Privacy is maintained during the delivery of personal cares and residents' information is held securely. Conversations about residents are undertaken behind closed doors in all areas of the facility. Each resident has their own room.</p> <p>Residents' records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and as far as possible incorporated into their care plan. On-site interdenominational church services are organised monthly and individualised activities focus on personal values and beliefs such as trips to local recreational and social facilities.</p> <p>There was no evidence of abuse or neglect and residents and family members noted they had not seen or heard anything of this nature. Policies on these topics guide any such event and the managers advised there is a zero tolerance for such behaviours. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There are not currently any residents who choose to have Maori culture integrated into their daily routines. Previous involvement with local iwi at the resident level is no longer required, although links remain for advice and support when required. The principles of the Treaty of Waitangi are known by staff who receive education on the topic alongside cultural safety and awareness training. All were aware of the importance of whānau to Māori residents.</p> <p>A Māori health plan advocates for use of the Te Whare Tapa Whā model when developing the personal care plan of any resident who identifies as Māori. A comprehensive flip chart on tikanga best practice is available and includes details of local cultural advisers.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p>	<p>FA</p>	<p>Residents and family members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. This was especially evident in the 'My Day, My Way' section of service delivery plans, which strongly reflect individual's culture, values and</p>

<p>respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>beliefs. This does not serve as a guidance for management of people with dementia over a 24 hour period (Refer criterion 1.3.5.2). Resident's personal preferences, required interventions and special needs were prominent throughout the care plans and staff openly talked about how these are being met for different residents.</p> <p>The new service provider has a cultural safety policy which states that services will be delivered in a culturally safe manner that acknowledges each individual's spiritual and cultural values, beliefs and needs.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff orientation programme includes information related to maintaining professional boundaries and expected behaviours. Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe.</p> <p>Aspects of expected conduct are included in staff position descriptions and in their individual employment contracts, which all staff sign as read and accepted. Staff are guided by organisational policies and procedures that aims to ensure the safety of both residents and staff. During interviews, staff described the processes they would follow should they suspect any such behaviours was occurring.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The current service provider encourages and promotes good practice through the use of experienced and knowledgeable staff at the organisational level of Bupa NZ where formats of care plans, policy and procedure documentation and best practice are determined. Registered nurses maintain their professional development to ensure good practice is implemented and executed. Use of external specialist services and allied health professionals, such as district nurses, the hospice/palliative care team, a physiotherapist, services for older people and mental health services for older persons complement the employed staff to ensure the best level of care possible is provided. The GP is satisfied that the staff seek prompt and appropriate medical intervention and advice when required.</p>

		<p>Other examples of good practice that were identified by the manager and/or observed during the auditor was the management and staff commitment to the residents. There was a focus on advocating for residents to receive high standards of care and support and for it be as much like a home for the people living at Waterlea, as is reasonably possible. The manager noted that her staff genuinely care about themselves and others and efforts to nurture this culture are ongoing. It was reported that actions are taken to ensure there is no differentiation, or discrimination, between the main rest home area and the 'Forget Me Not' unit. This was reflected in staffing levels, meals and the overall environment including furniture, for example.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Open disclosure was evident in residents' records, which include well documented family/whānau communication records. In addition, completed and signed incident/accident reports demonstrated that the manager or a registered nurse is following up with family regarding any such resident related event.</p> <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status. They reported they are advised in a timely manner about any incidents or accidents and any changes in the health status of their relative. Records of family and resident input into initial care planning and multi-disciplinary reviews was evident in residents' records that were reviewed.</p> <p>Staff spoken with were familiar with the policies and procedures on open disclosure, which meet the requirements of the Code.</p> <p>The manager informed that if required, interpreter services are able to be accessed via a personal contact of the facility manager who is associated with local immigration services. Policies and procedures also include details of interpreter service contacts through the local district health board. The manager and long term staff could not recall ever needing such services and that family would play an important part for any resident who could not speak English. Staff within the dementia service were observed using hand signals as well as speech when managing these residents.</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>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The facility manager is responsible for documenting annual objectives and managing the associated operational plans. A sample of weekly and monthly reports to the operations manager showed adequate information to monitor performance is reported including financial performance, emerging risks and issues.</p> <p>The service is managed by a facility manager who holds relevant qualifications and has been in the role for many years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at the BUPA managers' forum and engagement with relevant local sector agencies.</p> <p>The service holds contracts with the local DHB for rest home and dementia care. There were 40 rest home residents 12 of whom were private paying and the rest were receiving services under the ARC agreement; 14 residents were receiving services in the dementia unit (Forget Me Not) at the time of audit.</p> <p>New Provider Interview January 2018: The new provider (Heritage Lifecare Ltd – HHL) is an established New Zealand aged care provider, currently operating more than 1100 beds in the sector. Waterlea Rest Home is one of 12 proposed facility acquisitions across the country. An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017). 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.</p> <p>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</p>

		<p>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.</p> <p>It is expected that the present senior team will remain in place at each facility and that existing staff will transfer to the new provider.</p> <p>The prospective purchaser has notified the relevant District Health Board prior to the provisional audit(s) being undertaken.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the facility manager is absent, the clinical manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by an RN who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>New Provider Interview January 2018: The prospective provider has no plans to make any significant staff changes during the transition period. 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.</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>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, and clinical incidents including infections.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and risk, health and safety, infection control and staff meetings. Staff reported their involvement in quality and risk</p>

	<p>management activities through audit activities, incident reporting and meeting attendance. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed satisfaction with the facility and services.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>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.</p> <p>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.</p>
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<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form or within the organisation's electronic system. A sample of incidents 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 to the operations manager and quality manager within the system and narrative is included by the facility manager within the weekly and monthly reports.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit.</p> <p>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 was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual 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 a three-month period.</p> <p>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</p>

		<p>the DHB. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. 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.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>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). An electronic tool provided by the organisation is used by the facility manager. The facility manager in conjunction with the clinical manager 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 and there is 24 hour/seven days a week on call manager or RN for the facility.</p> <p>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 confirmed understanding of the required skill mix to ensure rest home and dementia 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.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately</p>	FA	<p>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</p>

<p>recorded, current, confidential, and accessible when required.</p>		<p>health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information being entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the manager, or a representative. Comprehensive information packages are available to people making enquiries and/or when people enter the service. The facility manager, clinical manager or a registered nurse is responsible for coordinating the admission process. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Policies and procedures for the management of exit, discharge or transfer processes were viewed and are aimed at reducing risks associated with these processes. Such processes are managed in a planned and co-ordinated manner, with a family member or staff escort present as appropriate. Feedback from a resident and their family member was positive about the manner in which such an event had been managed.</p> <p>The service provider uses the DHB's 'yellow envelope' system to</p>

		<p>facilitate the transfer of residents to and from acute care services. This enables relevant documentation to accompany the resident. Managers and staff described the open communication that occurs between all services, the resident and the family.</p> <p>The clinical manager explained that if a person is transferring to a different facility, then the roster is amended to enable a registered nurse to escort the resident and ensure a verbal handover, as well as for the transfer of documentation. The entire resident's file is handed over if the person is transferring to another Bupa NZ facility, such as to their nearby hospital level care facility.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management, with the use of an electronic system, was observed during the mid-day medicine round on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities. Documented evidence was provided that confirmed staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged robotic format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription and signed as correct on entry to the facility. All medications sighted were within current use by dates. Unused medicines are returned to the pharmacy and clinical pharmacist advice and input is provided on request.</p> <p>Controlled medicines are stored securely in accordance with requirements. Each medicine is checked weekly by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>Records of temperatures for the medicine fridge and the medication room are consistently checked daily and were within the recommended range.</p> <p>The use of the One Chart electronic medication management system</p>

		<p>facilitates the prescribing practices including detail around commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. Required three monthly GP reviews are being consistently recorded in medicine records and in residents' files.</p> <p>There are not currently any residents who were self-administering their medicines at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner should it be considered for a resident.</p> <p>Medication errors are reported to the senior registered nurse on duty and to the manager. Such events are recorded on an accident/incident form and followed up as per the usual incident/accident reporting process. 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. Standing orders are not used in this service and because of the use of One Chart, there is no need for a verbal order process.</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>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Records of these were sighted attached to the bain-marie food serving trolley. The cook and two care staff confirmed that residents in the secure dementia service have access to food and fluids to meet their nutritional needs at all times of the day and night. Special equipment, to meet resident's nutritional needs, is available when required.</p> <p>The food service is provided on site by a cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu that was reviewed by a registered dietitian just over two years ago rotates on a four weekly basis with summer and winter variations. An email from Bupa NZ confirmed the menu is currently under review; however, the new provider Heritage Lifecare has their own menu which will be introduced over time.</p> <p>All aspects of food procurement, production, preparation, storage,</p>

		<p>transportation, delivery and disposal comply with current legislation and guidelines. A new kitchen has been built and installed since the last audit, although an improved ventilation system has yet to arrive. The service operates with an approved food safety plan that had a registration issue date of 22 September 2017. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food service manager has undertaken a safe food handling qualification and is scheduled for another early this year. Kitchen assistants have completed relevant food handling training.</p> <p>Without exception, residents and family members who were interviewed during the audit were fully satisfied with the meals, albeit some described it as 'institutional'. Discussion on food/menu preferences was evident in residents' meeting minutes, although there were no significant comments of dissatisfaction. Observations made during the audit demonstrated that the food was well presented on the plate, residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance and encouragement is available to residents as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>Entry criteria for Waterlea is advertised on a website, printed brochures and in packages of information provided to people who make enquiries. The manager informed that if a referral is received but the prospective resident does not meet the entry criteria, or there is not a vacancy at the time, then the local NASC is advised. Priority is given to people who have previously received respite care, so long as there is a vacancy and Waterlea can provide suitable ongoing services. The manager reported that a suitable placement is pursued by the NASC service to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>There is not currently a waiting list as there are seven empty beds, five of which are in the dementia service.</p> <p>A clause in the admission agreement signed by the resident / family member or EPOA notes the grounds for termination of the agreement.</p>

		<p>If the needs of a resident living in Waterlea change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made. An example of this was occurring during the audit. The process of finding a new residence is reportedly done in consultation with the resident and whānau/family.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, a nursing assessment is completed, as is a nutritional assessment. An activities assessment is completed within three weeks of admission and a cultural assessment is completed within six weeks. The primary assessment process, which is completed within three weeks of admission and reviewed six monthly is the interRAI assessment. All residents have up to date interRAI assessments completed by one of the four trained interRAI registered nurse assessors on site.</p> <p>Information obtained from interRAI is further developed using validated nursing assessment tools as indicated. Examples of these include a pain scale, falls risk assessment, skin integrity assessment and nutritional screening. Once obtained, the information is collated to inform care planning.</p> <p>The sample of care plans reviewed had an integrated range of resident-related information obtained from the pre-admission needs assessments, clinical reports, a GP review, formal assessment tools and interviews with key people such as the resident, family member(s) and others who may have been involved in their care and support prior to admission. Individualised goals had been developed as a result of these assessment processes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Service integration, including from external professionals and services was evident in the care plans reviewed, which reflected the care and support needs of the residents. All were individualised and demonstrated changes have been documented when a person's needs or situation has changed. A template is used consistently between residents across both rest home and dementia services. Progress notes, activities notes, medical and allied health professional's updates</p>

		<p>were clear, relevant and informative. Residents and families reported participation in the development and ongoing evaluation of care plans. For new or short term problems, short term care plans are being developed. These are evaluated within appropriate timeframes and signed off when resolved; otherwise the issue is integrated into the long term care plan. Likewise specific nursing plans for wound or diabetes management, for example, were in place as relevant.</p> <p>The same format and processes for service delivery plans were evident in the residents' files reviewed in both the rest home and the dementia service. There was evidence of behaviour monitoring and interventions in care plans for people in the dementia service and additional details for identifying and managing signs of distress. Detailed activity plans are in place; however, none of the four residents' files reviewed in the dementia service included a twenty four hour activity plan for individual diversional, motivational and recreational therapy, as required by the Age Related Residential Care (ARRC) Agreement.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Services being delivered are consistent with the assessed needs, individual goals and personal preferences of residents. Residents stated they are well looked after, do not want for anything, have all their needs met and the staff know what they are doing. Family members interviewed were fully satisfied with the level of care being provided at Waterlea Rest Home. Observations made throughout the audit verified that staff are aware of individual needs and intervene accordingly. Progress notes and reviews demonstrated that services provided are in line with individual resident's assessed needs and their different personal goals.</p> <p>Attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP verified during interview that medical input is sought in a timely manner, medical orders are followed and care is consistent with the level of need they are presenting. According to the GP, the nursing staff are also aware of when significant changes have occurred for a resident and are proactive when reassessments for a different level of care is indicated.</p>

		<p>Care staff confirmed that care and support is provided as outlined in each resident's documentation, information provided at handovers by the registered nurse. And as per registered nurse instructions. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by one diversional therapist, who holds a national Certificate in Diversional Therapy, two assistants and casual volunteers.</p> <p>A social assessment and history is progressively undertaken following admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are reviewed six monthly and as needed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted for both the rest home and dementia service areas match the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities, outings and regular events are offered. Examples include outings, games, quizzes, music, entertainment, homelike activities, art and crafts, exercises and walks, for example. The activities programme is discussed at the minuted residents' meetings. Rest home residents who were interviewed confirmed they do not attend everything on the programme but stated there was a range of different activities, which caters for personal interests available</p> <p>Activities for residents living in the secure dementia unit are specific to the needs and abilities of the people living there. Group and one on one activities are primarily offered between 10 and 4pm during the daytime. As noted for corrective action under criterion 1.3.5.2, activity guidelines for individuals do not cover 24 hours, as required in the ARRC agreement/contract.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse who is responsible for reviewing the situation and taking any relevant action(s).</p> <p>Formal multi-disciplinary 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 registered nurse. Where progress is different from expected, the service responds by initiating changes to the plan of care.</p> <p>Examples of short term care plans, such as for skin tears, behaviour changes or infections, were consistently being reviewed. Progress on short term care plan goals is evaluated within timeframes as clinically indicated and depending on the degree of risk noted during the assessment process. Other plans, such as for wound management are evaluated each time the dressing is changed. Residents and families/whanau who were interviewed provided examples of their involvement in the evaluation of care planning goals and interventions and any changes. They reported that if unable to attend that nursing staff update them after the meeting.</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>	<p>FA</p>	<p>During reviews of residents' files it was evident that residents are referred to other health and disability services when necessary, as copies of referral documents were sighted. Other residents are being supported to continue with specialist services they may have used prior to admission.</p> <p>The clinical manager described links between the service provider and contracted service providers, such as a podiatrist and a physiotherapist. Services such as occupational therapy, psycho-geriatricians, mental health and specialist consultants (eg, urologists), are accessed via referral to the relevant departments via the local Wairau hospital. Strong links are maintained between local NASC services and the Waterlea Rest Home, which refers prospective residents and facilitates the reassessment of residents for a different level of care should the need arise. One GP attends to the majority of residents within the service, although when feasible, residents may still</p>

		<p>choose to remain with their own.</p> <p>Family communication records show that family are kept informed of visits to or from external health and disability providers. Residents stated they believe they receive the input they need from external clinical and review services. Examples of emergency and acute referrals being attended to were reported by the clinical manager.</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>	PA Low	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. 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. Spill kits were available. The facility's hazard register describes the 'hazardous substance register' as part of the controls for chemicals, however, there is no hazardous substances register. There is a reliance on the external provider, although they do not control the other chemicals onsite.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 22 June 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the facility manager who is responsible for maintenance and observation of the environment. The environment was hazard free, residents were safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any</p>

		<p>repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>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 facilities.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes the rest home and dementia unit rooms, which have hand basins in each room, shared showers and toilets, and an ensuite in the larger apartment rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>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. Door width and room size is adequate for the resident groups.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required within their own rooms. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry and by family members if requested. Care staff and dedicated laundry staff</p>

<p>laundry services appropriate to the setting in which the service is being provided.</p>		<p>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.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff are undertaking the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and residents' satisfaction.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>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 describe 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 15 August 2003. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 5 September 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the number of residents. Water storage is located around the complex. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time at night and staff call 111 for Police assistance if required.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and all rest home rooms have doors that open onto outside garden or small patio areas. Heating is provided by underfloor heating in all but two residents' rooms and in the communal areas. These two residents' rooms have ceiling heaters. The dementia unit has air conditioning/heat pumps. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. Infection control management is guided by a comprehensive infection control manual, developed by Bupa at the wider organisational level.</p> <p>The clinical manager/registered nurse is the usual designated IPC coordinator, whose role and responsibilities are defined in a job description. While on extended leave, a replacement clinical manager is relieving in this position.</p> <p>Infection control matters, including surveillance results, are reported monthly to the facility manager and tabled at the quality/risk committee meeting. This committee includes staff representatives from throughout the different areas of the facility, including food services and household management.</p> <p>Depending on the season, signage is placed at the main entrance to the facility requesting 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 if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>The relief infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role, and undertakes this</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>role in another facility. She is suitably qualified and experienced for the role having attended ongoing updates on infection control topics.</p> <p>The facility GP is the first line of infection prevention and control information, although it was reported that there are also well-established local networks with the infection control team at the DHB and the local public health unit. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection prevention and control coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. A pandemic and an outbreak kit were sighted.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. The manager informed that these documents are currently under review. The new provider (Heritage Lifecare Limited) has their own set of infection prevention and control policies and procedures, which includes definitions of infections and an identification of infections form. There is a notifiable diseases list and a description of the surveillance of infections. Policies and procedures are reviewed two yearly, as with all documentation. The infection prevention and control programme is reviewed annually, as is required by these standards.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the documented infection control programme. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by</p>

		<p>suitably qualified registered nurses, and the infection control coordinator. When an infection outbreak or an increase in infection incidence, such as a recent increase of gastro-intestinal infections (suspected norovirus) has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing and advice about remaining in their room if they are unwell. Staff acknowledge the additional difficulties with this for people in the 'Forget Me Not' unit. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions.</p> <p>A Heritage Lifecare Limited manager informed that infection prevention and control and standard precautions are included in the education programme. Staff receive annual training after orientation.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented on an infection record form and entered into the electronic adverse event recording system. The infection control coordinator reviews all reported infections. Monthly infection surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Graphs are produced that identify trends for six month periods.</p> <p>A suspected norovirus outbreak, when a number of people experienced gastro intestinal symptoms, was contained. A documented review of the actions taken was sighted as was evidence of staff education having been provided.</p> <p>Internal infection control audits are completed six monthly and results are reviewed. Results of the surveillance programme and the internal audits are shared with staff via regular staff meetings, at staff handovers and through monthly organisational quality meetings, which</p>

		<p>include infection updates.</p> <p>The new provider will implement similar systems whereby infection data is collated by the quality manager and reported through the senior management team to the general manager and board of Heritage Lifecare Limited (HLL). Benchmarking of data across the HLL facilities is to occur in the future.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Waterlea Rest Home promotes a restraint free environment. The organisation's 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 clinical manager provides support and oversight for enabler and restraint free management in the facility and demonstrated an understanding of the organisation's policies, procedures and practice and staff roles and responsibilities.</p> <p>Staff interviewed indicated they have received training in maintaining a restraint free environment and on the day of audit, two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. Staff stated there is no restraint use at Waterlea, although use of a personal restraint was identified as indicated in the standards below.</p> <p>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.</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</p>	PA Low	<p>The BUPA restraint approval process described within the suite of policies and procedures includes the approval of four physical restraints and one enabler. There is no reference to the use of personal restraints or the inclusion of this practice in service delivery.</p>

<p>procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>There is one resident using personal restraint at the time of audit.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>PA Low</p>	<p>Waterlea staff were not aware of the need to ensure an assessment was completed prior to using a personal restraint. Therefore, there was no restraint assessment record in the file of the resident who was observed being physically restrained.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>PA Low</p>	<p>During interview staff stated the personal restraint in use was undertaken with care as a last resort using the least amount of force. The intervention was undertaken to support the resident with personal hygiene and normal daily activity, such as dressing. The restraint was planned in the privacy of the resident's room with adequate staff to ensure resident and staff safety. Staff indicated; the resident's increasing challenging behaviour over the last two weeks had been noted, that a reassessment was required to better support the resident, and that this would most likely result in an increase in the level of care provided to safely support the resident.</p> <p>The resident's file did not contain records of restraint episode evaluation or detail about the use of the personal restraint.</p> <p>There is a system available to Waterlea staff, described within BUPA's policies and procedures to record and report against restraint use within the quality meetings. Currently the restraint free status is recorded as the personal restraint in use had not been identified as a restraint.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>PA Low</p>	<p>Residents' care plans are being evaluated to include behaviour monitoring, however the use of personal restraint to enable the support of one resident with activities of daily living, such as getting dressed, has not been recognised or recorded as a restraint therefore episodes have not been evaluated.</p> <p>Compliance with criterion 2.2.4.2 was unable to be assessed as no</p>

		evaluation of the use of restraints has occurred.
<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 quality meeting minutes indicated review and endorsement of Waterlea Rest Home's restraint free status. No audit activity has identified the practice of personal restraint to restrict a resident's movement as an unapproved restraint. The quality meeting minutes stated that no restraints have been used as staff do not recognise the practices being used as a restraint. Education on maintaining a restraint free environment was evident in staff files and interviews. Monitoring and evaluation of the personal restraint being used was evident in the individual's care plan sighted, as part of behaviour monitoring and interventions.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Comprehensive activity assessments and plans were in all residents' files; including in the dementia service. A document titled 'My Day – My Way' is in place and describes preferences and basic routines over a day, but this does not guide staff to manage the resident beyond the hours an activity programme is in place. Residents' service plans do not include an individualised twenty four hour activity plan, as required in the ARRC agreement. Staff interviewed were unaware of this requirement.</p>	<p>Residents in the dementia service do not have a 24-hour activity plan as required in clause E4.3b iv of the ARC agreement.</p>	<p>All residents in the dementia service shall have a description of the activities that meet their individual diversional, motivational and recreational therapy over 24 hours.</p> <p>180 days</p>
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and</p>	PA Low	<p>There is no hazardous substances register which describes the storage requirements and incompatibilities of the chemicals used in the facility,</p>	<p>The potential risk of hazardous substance storage has not been recognised or</p>	<p>Review the quantities, storage locations and incompatibilities of the chemicals held onsite not just those supplied by the external</p>

<p>disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>		<p>which if accidentally combined are a potential risk to staff and others. The safety data sheet information and lists available from the external provider does not provide the level of assurance a hazardous substances register is required to provide. Staff interviewed were unaware of the need of, or potential consequences of, the lack of a hazardous substances register or the risk mitigation opportunity this would provide.</p>	<p>addressed. There is no hazardous substance register as referred to in the hazard register.</p>	<p>supplier. Consider the safe removal of chemicals no longer used and create a hazardous substance register which provides assurance actual and potential risk is being minimised.</p> <p>180 days</p>
<p>Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.</p>	<p>PA Low</p>	<p>The BUPA restraint policies and procedures include approved restraints which are bed sides, lap belts, chairs with tables, lazy boys, and a sitting safe enabler. When bed sides are used, bed protectors are to be used with them at all times. Approval for restraint use is required to be consented to by the EPOA on behalf of the resident, following assessment by the RN and the clinical assessment / opinion of the GP, physiotherapist or other allied health professional. The cultural safety policy refers to incorporating the resident's culture, values and beliefs into the restraint assessment process. However, there is no reference to personal restraint use. Personal restraint is being used to support a resident with personal cares.</p>	<p>The restraint policies and procedures do not clearly define restraint processes and how all aspects of the standard will be met including accountability for use of personal restraint.</p>	<p>Ensure restraint minimisation and safe practice policies and procedures describe how all aspects of the standard will be met, including restraint approval and the lines of accountability for personal restraint.</p> <p>180 days</p>

<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <ul style="list-style-type: none"> (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies. 	<p>PA Low</p>	<p>Staff were unaware that they were using personal restraint when two staff were holding a resident's arms to enable personal cares to be provided. No detail of this action was recorded within the resident's file.</p>	<p>There was no evidence in care plans of assessments having been completed for the use of the personal restraint being used on the day of audit.</p>	<p>Prior to the use of personal restraint with any resident, the factors as listed in this criteria (a) to (h), plus any others indicated, will be used to assess the associated risks.</p> <p>180 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is</p>	<p>PA Low</p>	<p>Staff were unaware their practice of holding the arms of a resident in the</p>	<p>There is no record in the resident's file, or in</p>	<p>Each episode of restraint, including personal restraint, is</p>

<p>documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>		<p>'Forget me Not' dementia unit, in order to carry out personal cares, constituted a personal restraint; therefore, no documentation has been completed for each episode as required by the standard.</p>	<p>evaluations and reviews that provide an indication for use, intervention, duration, or outcome of the personal restraint use.</p>	<p>recorded in enough detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and includes factors listed in (a) to (g) of this criterion.</p> <p>180 days</p>
<p>Criterion 2.2.4.1</p> <p>Each episode of restraint is evaluated in collaboration with the consumer and shall consider:</p> <p>(a) Future options to avoid the use of restraint;</p> <p>(b) Whether the consumer's service delivery plan (or crisis plan) was followed;</p> <p>(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);</p> <p>(d) Whether the desired outcome</p>	<p>PA Low</p>	<p>Staff were unaware that holding the arms to physically restrain a resident is a form of restraint. Assessment and ongoing reporting of its use is not occurring; therefore, episodes of personal restraint use have not been evaluated as required by the standard.</p>	<p>The episodes of personal restraint being used with one resident are not being evaluated as required by the standard.</p>	<p>Each episode of restraint is evaluated according to the requirements as listed in this criterion (a) to (k).</p> <p>180 days</p>

<p>was achieved;</p> <p>(e) Whether the restraint was the least restrictive option to achieve the desired outcome;</p> <p>(f) The duration of the restraint episode and whether this was for the least amount of time required;</p> <p>(g) The impact the restraint had on the consumer;</p> <p>(h) Whether appropriate advocacy/support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;</p> <p>(j) Whether the service's policies and procedures were followed;</p> <p>(k) Any suggested changes or additions required to the restraint education for service providers.</p>				
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.