

Heritage Lifecare (BPA) Limited - Riverside Care Home and 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](#).

The specifics of this audit included:

Legal entity: Heritage Lifecare (BPA) Limited

Premises audited: Riverside Care Home and Hospital

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

Dates of audit: Start date: 15 January 2018 End date: 16 January 2018

Proposed changes to current services (if any): The 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.

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Total beds occupied across all premises included in the audit on the first day of the audit: 60

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

Riverside Care Home and Hospital provides rest home, dementia, and hospital level care (geriatric and non-acute medical) for up to 65 residents. On the first day of audit, there were 60 residents. The service is presently operated by Bupa Care Services NZ Limited and managed by a Care Manager and a Clinical Manager who have been in their respective roles for approximately one year. Both are familiar with the operation through their previous Bupa roles. Residents and families spoke positively about the care provided.

This provisional audit was undertaken to establish the prospective owner's preparedness to provide a health and disability service and the level of conformity with the required standards for both rest home, long stay hospital/medical and dementia care services. The audit was conducted against the Health and Disability Services Standards and the provider's contracts with the Taranaki District Health Board (TDHB). The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau, management, staff, a general practitioner, contracted physiotherapist, the current provider and the prospective owner. Bupa are well-developed systems, processes, policies and procedures that are

structured to provide appropriate quality care for people who use the service, including residents that require hospital/medical, dementia and rest home level care.

This audit has identified areas of improvements relating to storage of waste and exterior and interior maintenance. Improvements have been made to corrective action planning and chemical storage, addressing those areas requiring improvement identified at the previous audit.

Consumer rights

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

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

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

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

A complaints register is maintained with complaints resolved promptly and effectively for the small number of complaints received.

Organisational management

Business and quality and risk management plans include the goals and values of the organisation. Monitoring of the services provided to the national office 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. Organisation wide policies and procedures support service delivery and are current and reviewed regularly.

The recruitment and appointment of staff is based on current good practice. A comprehensive organisation wide programme is implemented for all staff groups. 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, with registered nursing cover provided 24 hours a day, seven days a week.

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

Continuum of service delivery

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

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

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

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

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

Safe and appropriate environment

Riverside Care Home and Hospital is an older facility. There is a current building warrant of fitness displayed. A 52-week maintenance schedule is in place to ensure maintenance occurs throughout the year and legislative requirements are met. Electrical and biomedical equipment is tested as required and hot water temperatures monitored and maintained within a safe range. Communal and individual spaces are maintained at a comfortable temperature. Bedrooms are sufficiently large to accommodate resident equipment and personal effects. External areas are accessible with suitable shade and seating.

Waste and hazardous substances are managed by external contractors. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Cleaning and laundry activities are undertaken by on-site staff 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. One bed side enabler and two restraints - a lap belt and ultra-low bed (as per Bupa policy) are in use at the time of audit. A comprehensive assessment, approval and monitoring process occurs with regular reviews undertaken. Use of enablers is voluntary for the safety of resident in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes. Use of restraint is reported monthly to national office.

Infection prevention and control

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

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| Standards | 0 | 48 | 0 | 1 | 1 | 0 | 0 |
| Criteria | 0 | 98 | 0 | 2 | 1 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation. | FA | The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| 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 | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff and include advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form and this was evident in eight of eight residents' files reviewed. Where a resident is deemed incompetent to make an informed choice the enduring power of attorney (EPOA) will consent on behalf of the resident. Staff were observed to |

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| | | gain consent for day to day care. |
| 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 and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The home care manager provided examples of when the involvement of Advocacy Services would be encouraged or utilised. |
| 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, younger and older, are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome and included when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints 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 three written complaints have been received over the past year and that actions were taken, through to an agreed resolution. These are documented and completed within the specified timeframes. Action plans showed any required follow up and improvements have been made where possible. The care home 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. There have been no complaints received from external sources since the previous audit. |

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| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussions with staff. The Code is displayed in the four main areas of the facility together with information on advocacy services, how to make a complaint and feedback forms.</p> <p>The prospective provider is an experienced aged care services 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.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor, participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence for all residents, younger and older.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | FA | <p>The home care manager interviewed stated that there are currently three residents who affiliate with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori, with staff able 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. There is no</p> |

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| | | specific current Māori health plan, however all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and evidenced in the care summary, map of life, identified in the interRAI assessment and integrated into long-term care plans with input from cultural advisers within the local community, who also provide guidance on tikanga best practice. The facility and residents are supported by a local Maori organisation who visit regularly and take residents interested in partaking in regular Maori based and facilitated weekly community events. Māori residents and their whānau interviewed reported that staff acknowledge and respected their individual cultural needs. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed 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. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| 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, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. One of the seven general practitioners who provide services was interviewed and confirmed the service sought prompt and appropriate medical |

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| | | <p>intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff have adapted to support residents who struggle with communication and use simple phrases and gestures that the resident (both younger and older) can easily respond to. Staff know how to access interpreter services, 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.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>The Bupa quality plans, which are reviewed annually, outline the priorities and goals of the organisation. The values are clearly displayed and made known to residents, staff and visitors. Documentation described annual and longer-term objectives and the associated operational plans, which links to the overarching Bupa strategy. A sample of monthly reports to national office showed adequate information to monitor performance is reported including clinical indicators, occupancy, staffing hours, expenditure and emerging risks and issues.</p> <p>The service is managed by a care manager who is a registered nurse. She has been in the role for just over one year, but previously worked in the facility as a clinical manager before being appointed to this role. Responsibilities and accountabilities are defined in a signed job description and individual employment agreement. The care manager confirmed knowledge of the sector, regulatory and reporting</p> |

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| | | <p>requirements and maintains currency through the Bupa leadership programme and infrastructure for managers as well as clinical practice education sessions. She is well supported by the two Northern Regional operations managers and the national office team. The regional group meet three monthly, to discuss progress towards the defined goals.</p> <p>The service holds contracts for long stay residential care (hospital and rest home), dementia care, respite care, complex medical conditions, palliative care plus younger persons with disabilities (YPD). Sixty residents were receiving services under the contracts on the first day of audit (16 hospital; 22 rest home; 16 dementia, four YPD – physical disability and 2 residents with intellectual disability). Five beds in the hospital/rest home are dual purpose.</p> <p>The new provider is Heritage Lifecare Ltd (HLL) which is an established New Zealand aged care provider, currently operating more than 1100 beds in the sector. An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017). Riverside is one of twelve proposed facility acquisitions 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.</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 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 at each of the facilities.</p> <p>The present senior team will remain in place at each facility during the transition period. It is anticipated that existing staff will transfer to the new provider. The prospective purchaser has notified the relevant District Health Board prior to the provisional audit(s) being undertaken.</p> |
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| <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> | <p>FA</p> | <p>When the care manager is absent, a Bupa appointed roving manager carries out all the required duties under delegated authority. A clinical manager/registered nurse (RN) is employed full-time. She supports the care home manager and steps in during any brief absences of the care home manager. The operations manager visits regularly to provide support to both managers.</p> <p>The support from the national organisation assists the facility's senior staff to provide an environment which meets the needs of both aged care residents and residents with disabilities.</p> <p>Interview with the prospective provider confirms their experience in the aged care sector as an existing national operator of a large number of aged care beds. 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. 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> | <p>FA</p> | <p>The organisation has a planned and implemented quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes and clinical incidents, including infections and restraint use. A quality and education role supports the implementation of the quality and risk system.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at these meetings. Quality, health and safety, staff and registered nurses' meetings occur to discuss operational matters. Staff reported their involvement in quality and risk management activities through involvement in audit activities and meetings. Relevant corrective actions</p> |

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| | | <p>are planned and implemented to address any shortfalls. Examples included plans to address an increase in infection rates and falls. Resident and family satisfaction surveys are completed annually. The most recent survey in 2017 identified a more family friendly space was desired by visiting families. This was addressed with the purchase of a lounge suite for the Serenity Unit. There is no dedicated family/whānau space.</p> <p>An annual internal audit plan/schedule and audit results evidences internal audits are planned to occur on a regular cycle, linked to the issues or problem areas. On occasion, audit frequency is increased to monitor that the corrective action has addressed the problem. Quality and risk data, including trends in data and benchmarked results, are discussed in registered nurse, staff and quality meetings and reported monthly in the managers' report. Emerging issues are also discussed each week at a managers' teleconference. Corrective actions are now documented in the samples reviewed.</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. A nationally implemented document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. One hard copy folder of all documents is available in the facility, with all master documents held electronically.</p> <p>The care 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>The new provider confirmed that 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 which includes 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> |
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| | | 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 | In the past six months, a national electronic risk management system has been introduced to capture and analyse adverse and near miss events. Information about any adverse event is entered into the system, along with any subsequent actions. Facility adverse event data is collated, trended over time and reported each month to Bupa. Reports sighted highlight any areas which are above the national benchmarks or there is a variance since the previous report. The care manager described essential notification reporting requirements, including for Section 31. They advised there have been no notifications of significant events made to the Ministry of Health, Worksafe NZ, professional bodies, or Coroner since the previous audit. 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 an understanding of actions to meet legislative and DHB contractual requirements for event reporting. |
| 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. | FA | Bupa 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 practicing certificates (APCs), where required. A sample of 10 staff records confirmed the organisation's policies are being consistently implemented and records are maintained. Files are systematically organized. |

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| | | <p>Staff orientation includes all necessary components relevant to the role. Caregivers undertake the standard Bupa induction which provides the staff member with a level 2 NZQA qualification at the end of their three-month orientation period. Registered nurses are initially supernumerary. Other staff groups also have specific orientation programmes. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review at the end of this time and annually thereafter.</p> <p>Continuing education is planned on an annual basis, including for compulsory and core training requirements. Attendance at mandatory training can be demonstrated for 75% of staff. Annual competencies augment the annual training plan relevant to each staff group, with relevant workbooks. Records are maintained. Cleaning staff are undertaking or have completed the national level 2 cleaning certificate. The staff member responsible for quality and education is the internal assessor for the programme and provides literacy support. Ninety three percent of staff working in the dementia care area have fully completed the NZQA level 4 certificate programme in dementia care, with others having completed their level 3 qualification. Other education is provided with 'toolbox' talks and regional education is provided by the local hospice and the Taranaki DHB. Offsite educations sessions have been well received and there is a notable increase and then sustained staff attendance at planned education.</p> <p>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> |
| 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. A retrospective tool which is updated fortnightly, provides data in relation to staffing hours. This meets contractual requirements, however there is presently no link to the acuity levels identified in the interRAI tool. The care manager states |

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| | | <p>that this data does help inform staffing decisions, however, presently acuity is high, with many complex 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, although there have been periods when delays in completing recruitment has put pressure on existing staff to fill the roster. Residents and family interviewed supported this.</p> <p>Observations and review of a two-week roster cycle (covering the past six weeks) confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Care staff have a mix of eight-hour shifts, with several shorter shifts used to cover busy periods. Household staff operate a separate roster. Registered nurses all hold a current first aid certificate. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital. They are also available to the rest home and hospital staff for advice and support when the clinical manager is not on site. The care home manager and clinical manager alternate call and both have worked shifts on the floor when the complement of RNs is insufficient.</p> <p>One of four activities staff (a trained diversional therapist) supports the residents in the dementia unit Monday to Thursday. Part of their role, together with another activity staff member, includes the daily pick up and drop off for up to three day-care residents, who attend the facility at varying times over a five-day period. The diversional therapist takes responsibility for the care of these residents during their stay in the facility. The activity staff are also responsible for the escort of residents required to attend hospital or other medical appointments, sometimes at short notice. At these times, a caregiver is assigned to provide cover for the activities programme in the dementia unit, or in combination with other planned rest home activities. This was observed to occur during the audit to ensure residents in the dementia unit continue to be adequately supported. (Refer also Standard 1.3.7).</p> <p>The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the indicators for safe staffing level. The representative for HLL interviewed could confirm understanding of the required skill mix to ensure rest home and dementia care residents needs are met. As an organisation, HLL</p> |
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| | | already provides a range of care levels (geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services. HHL have the experience to deliver the levels of care currently provided by Riverside Home and Hospital. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. The latest archived records are held securely on site and are readily retrievable using a cataloguing system. The home care manager interviewed stated that the organisation holds older records off site and in a secure building not able to be viewed at the time of audit. 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 young and older enter the service when their required level of care has been assessed, which includes a specialist review for residents entering dementia care and evidence of EPOA which has been enacted showing consent for the resident to be admitted all of which has been confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from NASC and the GP 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 on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance |

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| | | with contractual requirements. Service charges comply 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 (or similar system) to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example of a patient transferred to the local acute care facility (December 2017) showed the use of the 'yellow envelope' and supportive documents, communication between the facility, family and acute hospital. Family of the resident reported being kept well informed during the transfer of their relative. |
| 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 (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. |

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| | | <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There were three residents self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> |
| 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. | FA | <p>The food service is provided on site by a kitchen manager two other cooks and a kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local council; this expires 22 September 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> |

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| | | Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| 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 is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. There were no examples of residents being declined to the service. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. 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 pain scale, falls risk, skin integrity, nutritional screening, challenging behaviours and depression scale, as a means to identify any deficits and to inform care planning when the resident is initially admitted to the facility. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of six trained interRAI assessors on site. The home care manager interviewed stated the intention is to train another two staff. Residents and families confirmed their involvement 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 resident's young and older, and the outcomes of the assessment process and other relevant clinical information. This included behaviour management plans including triggers and interventions for behaviours, the support required encouraging residents to participate and continue to be part of the community, which were integrated throughout the long-term care plan. The needs identified by the interRAI assessments were reflected in care |

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| | | <p>plans reviewed.</p> <p>Care plans evidenced service integration, with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The activities programme is provided by two recently trained diversional therapists holding the national Certificate in Diversional Therapy, an activities co-ordinator who is also a registered nurse with a current practising certificate and one activities assistant. The activities staff work Monday to Friday and provide support from 9am to 5pm. The activities team are also required to support residents off site. Care staff were observed at time of audit to support residents in the dementia unit with activities (please see Standard 1.2.8).</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.</p> <p>Young persons with disabilities are encouraged to partake in activities of interest to them and this includes helping with their day to day household chores, attending the local gym and mobile library, going out</p> |

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| | | <p>with family and friends and attending activities with the local Maori iwi organisation.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings. Residents interviewed confirmed they find the programme interactive.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there and care plans identify the resident's individual diversional, motivational and recreational requirements over a 24-hour period. Activities are offered at times when residents are most physically active and/or restless. This includes walks and one to one activities.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to physiotherapy, the hospice and to a clinical nurse specialist. The resident and the family/whānau are kept</p> |

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| | | <p>informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | PA Low | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Waste management removal is contracted to an external provider, with general waste collected from the site three times weekly. Placement of some waste bins requires review. Appropriate signage is displayed where necessary.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Records of training confirmed that this occurs and that staff are about to commence or have completed the level 2 cleaning qualification. Chemical and blood spills kits are available. Chemicals are all labelled correctly.</p> <p>The cleaners have a locked cupboard to store the cleaning trolleys when they are not in use. A locked cleaners' trolley is in use in Serenity Unit to address a previous corrective action. Material safety data sheets are available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment, staff understood its use and were observed using this appropriately.</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> | PA Moderate | <p>A current building warrant of fitness (expiry date 15 December 2018) is publicly displayed.</p> <p>There is a BUPA wide maintenance system which is implemented locally on the 52-week schedule as required. A maintenance person is employed for five hours per day to undertake this work and any day to day maintenance or repairs required. However, there are aspects of maintenance that are not consistently addressed (see CAR 1.4.2.4).</p> <p>The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed,</p> |

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| | | <p>interviews with maintenance personnel and inspection of the environment and equipment. Hot water temperature testing occurs regularly with temperatures maintained within safe limits below 45 degrees Celsius. Suitable facility and individualised equipment is available to provide the required level of care.</p> <p>The rear site appropriate to the needs of the resident groups and setting. There are sealed car parking areas and paths. Shade is available in outdoor areas. However, not all external areas promote independence or are safe for residents (see CAR 1.4.2.6).</p> <p>The dementia unit (Serenity Unit) includes a conservatory, combined dining room/lounge and a secure outdoor area with an old car available for tinkering, a post box, washing line and garden. Residents from Serenity Unit also spend time accompanied by staff into other parts of the facility or on outings. The service has a leased van with a hoist available for use on outings or medical appointments.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>The new provider is yet to consider priorities for the facility and environment.</p> |
| 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 | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes communal bathrooms located close to resident lounge areas, toilets and hand basins, including a shared ensuite. Thirty-four rooms have toilet facilities. Appropriately secured and approved handrails and privacy locks are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Showers and toilet areas are in good repair with easy to clean and intact surfaces.</p> <p>Toilets in communal areas are clearly designated with signage and with blue doors in the Serenity Unit. Vinyl flooring has been installed for ease of cleaning as part of planned refurbishment.</p> |

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| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | <p>FA</p> | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation and have room to facilitate the safe use and manoeuvring of mobility aids. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is limited storage for mobility aids, wheel chairs and mobility scooters, however, this is managed safely. Clutter is actively minimised as part of the falls reduction programme. 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> | <p>FA</p> | <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. Furniture is appropriate to the setting and residents' needs. There are suitable lounge and dining spaces for rest home and hospital residents. Residents can move freely with mobility aids. The sloping corridor is well managed, with staff support available for residents who need assistance to negotiate the incline.</p> <p>Serenity Unit accommodates up to nineteen residential care residents, but can have up to three further day care residents present during the week. There is an adjacent open plan dining area. Residents, including those attending for day care, utilise accessible outdoor areas and spend time in the adjoining rest home to participate in activities suited to their need and abilities and to socialise with other residents.. Efforts have been made to create a homelike environment, with the recent purchase of a lounge suite to help create a more intimate space for this resident group.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | <p>FA</p> | <p>Laundry is undertaken on site in a dedicated and suitably equipped laundry by staff who 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. One complaint had been received in</p> |

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| | | <p>relation to lost garments, however this was adequately resolved.</p> <p>There is a small cleaning team who have received appropriate training. These staff are undertaking or have completed the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals are stored in a locked cleaning room in appropriately labelled containers. Safety data sheets and personal protective equipment is readily available and seen to be used by staff.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. Ongoing issues identified at audit have been managed through a corrective action process over the past year. This is now almost complete, with the anticipated appointment of additional cleaning staff later in the week of audit. There are days in which the cleaning schedule cannot be maintained due to staffing shortages, particularly at weekends. However, on the days of audit, the facility was clean, tidy and odour free.</p> |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | <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 describes the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 11 July 2013. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in October 2017. Records support that regular fire drills are occurring. 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 torches to meet the requirements for up to 65 residents. A water storage tanks is located near the laundry to provide additional water to the laundry if required. There is emergency lighting (tested in an extended power outage in the past year) and gas cooking available in case of power outages. There is no generator on site.</p> <p>Call bells alert staff to residents requiring assistance. Call system</p> |

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| | | <p>response times are monitored. There is no general assistance call bell in the shared toilets area. Instead, residents requiring assistance use the available emergency call point in each toilet for gaining staff attention. This was observed during audit, with staff taking prompt action when the call bell was activated. Registered nurses and diversional therapists taking residents off site have current first aid certificates including for cardio pulmonary resuscitation response.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a contracted security company checks the premises at night. Call bells are on hand in residents' rooms.</p> |
| 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 | <p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and there is access to the garden from some lounges and hallways. Heating is provided by individual thermostatically controlled ceiling heating in residents' rooms and by heat pumps/air conditioning in the communal areas. Records are maintained of ambient room temperatures, which are mostly in recommended range, however, areas were noted to be very warm on the two days of audit in mid-summer. Efforts had been made to increase cross ventilation and air movement to improve resident and staff comfort.</p> <p>There are designated smoking areas provided for residents and staff.</p> |
| 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 | <p>The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the organisation's operations manager who is a registered nurse and quality services improvement team. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse (not available at the time of audit) is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported at the monthly infection control meeting and staff</p> |

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| | | <p>meetings. This committee includes the home care manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Staff discourage visitors from visiting the facility when unwell. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> |
| 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 | <p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for one year. She has undertaken certificates in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p> |
| 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 | <p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p> |
| Standard 3.4: Education The organisation provides relevant education on infection control to | FA | Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing |

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| all service providers, support staff, and consumers. | | <p>education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when a resident was diagnosed with an infrequent one-off infection and antibiotics were charted by the GP. Documentation showed 18 staff attended a 'toolbox' session.</p> <p>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, and increasing fluids during hot weather.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, eye, gastro-intestinal tract, the upper and lower respiratory tract, and wound infections. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and 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 facility and clinical manager and the organisation as a whole. The facility benchmarks indicators per 1000 resident bed days and is also benchmarked externally with 65 other facilities within the organisation. Benchmarking has provided assurance that infection rates in the facility are below average for the sector with a total of 16 residents treated with antibiotics for an infection over the last six months.</p> <p>A summary report for a recent gastrointestinal infection outbreak in December 2017 was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p> |

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| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | <p>Bupa policies and procedures meet the requirements of the restraint minimisation and safe practice standards, include definitions and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the Care Home Manager. She 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 responsibilities.</p> <p>On the day of audit, two residents were using restraints (Lap belt and an ultra-low bed) and one resident was using an enabler (single bed side), which was the least restrictive and used voluntarily at their request. Assessment, monitoring and evaluation are consistently completed. These residents have used these intervention for some time, and there is evidence of three monthly reviews occurring. A similar process is followed for the use of enablers as is used for restraints. No new restraint has been initiated in the past year. Restraint is included in the annual compulsory training days for clinical staff. There is follow up for any non-attendance.</p> <p>Restraint is used as a last resort when all alternatives have been explored. Restraint is a standing agenda item at the monthly quality meeting. Use of restraint and enablers is also reported nationally, benchmarked and reviewed as part of the monthly clinical indicator report. The three files reviewed of residents currently using a restraint or enabler, interview with staff and the restraint coordinator confirmed the processes are consistently implemented in accordance with the standard.</p> |
| Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | <p>Staff applying restraint, complete an annual competency assessment. It was evident from review of quality meeting minutes (includes restraint as an agenda item), residents' files and interviews with the coordinator that lines of accountability are clear, that all restraints have been approved, and the overall use of restraints is being monitored and analysed, and use minimised as far as possible.</p> <p>Evidence of resident, family/whānau/EPOA involvement in the decision</p> |

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| | | making was on file in each case. Use of a restraint or an enabler was part of the plan of care in each example reviewed. |
| Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement and oversight, and with input from the resident's family/whānau/EPOA. The restraint coordinator described the documented and implemented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed interRAI assessments, together with the restraint assessment sighted in the records of residents who were using a restraint are supported by thorough and detailed care planning. |
| Standard 2.2.3: Safe Restraint Use Services use restraint safely | FA | The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with the resident where able, staff and family members (eg, the use of sensor mats, ultra-low beds and mattresses). When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register for both restraints and enablers is maintained, updated every month and reviewed at each quality meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record. Staff have received training, including scenarios, in the organisation's policy and procedures and in related topics, such as positively supporting people with behaviours that challenge. Staff spoken to understood that the use of restraint is to be minimised and how to |

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| | | maintain safety when in use. |
| Standard 2.2.4: Evaluation Services evaluate all episodes of restraint. | FA | Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, three monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process. Evaluation occurs monthly as part of the clinical manager's monthly review and three-monthly as part of the ongoing reassessment for residents on the restraint register and as part of their care plan or multidisciplinary review. Evaluation timeframes are determined by risk levels in accordance with the policy which covers all requirements of the Standard. |
| Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint. | FA | Individual restraint use is reviewed monthly at the quality meetings. Bupa uses results from benchmarking across the group to identify trends in restraint use, with minimisation and elimination of the intervention where possible. Riverside Care Home and Hospital has had no new restraint implement in the past year. There are regional restraint approval meetings (via teleconference) to monitor use and complete the quality review of restraint. Any learning is disseminated to the wider group of facilities. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the restraint coordinator and the clinical manager confirmed that the use of restraint has been reduced year on year. The restraint coordinator is actively reviewing the need for ongoing use for the two residents presently using restraint, with a view to eliminate its use if possible in response to the changing needs of these residents. |

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) |
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| Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Low | A building programme in the dementia unit has been completed, necessitating relocation of the bins outside a previously secured area. This includes placement of the large “skip” which now obstructs an entry footpath resulting in footpath users needing to walk on the roadway. The medical waste bin is not secure, with waste bins no longer behind a secure gate. | Waste bins obstruct a resident footpath at the entrance to the facility. The medical waste bin in the same area is accessible to residents and visitors. | Ensure the safe positioning and security of waste management bins. 180 days |
| Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | A maintenance book details day to day maintenance issues. Review of these records confirmed completion of requested maintenance is not routinely signed off or verified as completed in two maintenance request books, spanning the past nine months. Staff reported delays in completing | There are aspects of routine and preventative maintenance which are not adequately completed. This includes day to day issues, as well as building related maintenance requests. | Implement the maintenance programme which fully addresses routine and preventative maintenance requirements. |

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| | | <p>some required maintenance (eg, wheelchairs, mobility aids).</p> <p>The building requires some maintenance and repair. Examples include, but are not limited to, broken exterior cladding, loose downpipes held together with duct tape, an uncovered hole in the deck of the ramp used as fire egress, sliding doors on the emergency cupboard off its runners and a hole in a wardrobe door in room 54.</p> <p>There are examples of requests for maintenance improvements to head office which have been in process for some time. This includes one of three maintenance sheds on site which is in poor repair, not fully secure and accessible to residents.</p> | | 90 days |
| Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | <p>A lawn area at the rear of the building is used for fire egress via a ramp from a lounge area. This area is uneven, with several "holes" in the lawn causing a trip hazard to those exiting on this side of the building. The boundary fence preventing resident access to an adjacent gully has been breached by a resident in the past two years (with no serious injury resulting) but this section of the fence has not been fully repaired.</p> <p>This area is also accessed from the laundry and other external doors from the corridor. Residents use this area to access a raised vegetable garden which is part of the activities programme. Paving is uneven, an insecure shed (see 1.4.2.4) can be accessed and there are pieces of obsolete equipment (eg. a hoist)</p> | <p>Some external areas, including a raised vegetable garden and shed, is accessible to residents and does not provide a safe environment for all users.</p> | <p>Make improvements to ensure the external area is safe and accessible.</p> <p>180 days</p> |

| | | | | |
|--|--|--------------------------------|--|--|
| | | obstructing the narrow access. | | |
|--|--|--------------------------------|--|--|

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 audit.

No data to display

End of the report.