

Heritage Lifecare (BPA) Limited - Broadview Rest Home & 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: Broadview Rest Home & Hospital

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

Dates of audit: Start date: 29 January 2018 End date: 30 January 2018

Proposed changes to current services (if any): This facility is being sold and this provisional audit is being undertaken to establish the prospective owner's preparedness to provide a health and disability service and the current level of conformity with the required standards

Total beds occupied across all premises included in the audit on the first day of the audit: 64

Executive summary of the audit

Introduction

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

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

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

General overview of the audit

Broadview Rest Home and Hospital provides hospital, rest home and dementia, mental health for older people and psychogeriatric level care for up to a maximum of 85 residents. A sale and purchase agreement with the prospective provider Heritage Life Limited, is anticipated to be enacted in April 2018. The facility is currently overseen by a full time employed manager who is experienced in managing aged care services. This person is supported by a clinical manager/registered nurse. Residents and families spoke positively about the care provided.

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

This audit identified six areas requiring improvement. These are related to informed consent, information management, activities, the external environment and review of the infection control programme.

Consumer rights

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

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

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

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

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

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

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

Organisational management

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

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identifying and delivering ongoing staff 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, and relevant residents' records are maintained in using an integrated electronic register and hard copy files.

Continuum of service delivery

The organisation works closely with the local Needs Assessment and Service Co-ordination Service and the specialist mental health team, 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. Shift handovers, care managers' reports and handover sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and

outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides some 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 which were 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 catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified a high level of satisfaction with meals.

Safe and appropriate environment

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

Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Onsite cleaning and laundry services are evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies. Staff respond to call bells. Security is maintained.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Enablers and restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a good knowledge and understanding of the restraint and enabler process.

Infection prevention and control

The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board, and the organisation's quality and risk manager.

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 data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	1	4	1	0	0
Criteria	0	116	1	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Broadview Rest Home and Hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Moderate	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is</p>

		<p>defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents in the secure unit and the psycho-geriatric (PG) unit had an EPOA in place. An improvement is required in the methods used for determining advance directives for people in the mental health unit.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p> <p>The service does not store or use body parts.</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>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family/whanau members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. A resident's wife visits regularly and has just recently agreed to become the resident's advocate, in addition to visits from an advocate from the "Supporting Families" service for mental health consumers.</p> <p>Staff were aware of how to access the Advocacy Service.</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 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. Improvements are required in relation to the range of activities and outings on offer to mental health and psychogeriatric residents. (Refer Standard 1.3.7). The younger person interviewed was satisfied with how the service facilitated access to community, friends and family.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>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 what to do if they had concerns.</p> <p>All complaints received are entered on to a month by month register. Review of the records for five complaints received in 2017, contained letters of acknowledgement, evidence of the investigations and actions taken within the required timeframes, and an agreed resolution. Action plans showed any required follow up and improvements have been made where possible. The care 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. Training on the complaints policy and open disclosure is provided to all staff annually. There have been no complaints investigated by the office of the Health and Disability Commissioner since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family 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 discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</p> <p>An interview with the prospective provider, verified that the provider is aware of their obligations to comply with the Code.</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>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. This was also confirmed by a younger person in the hospital wing.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room.</p>

		<p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</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>There are three residents in Broadview Rest Home and Hospital at the time of audit who identify as Maori. Evidence verified the service supports residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from a cultural advisor and kaumatua.</p> <p>There were no Maori residents in the mental health unit on the days of audit, but the organisation employs a number of staff who identify as Maori. Training records showed that staff have attended education on the care of people who identify as Maori. Management described that ways in which resources and support for Maori residents and their whanau can be arranged.</p>
<p>Standard 1.1.5: Recognition Of Pacific Values And Beliefs</p> <p>Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>During this audit there were no Pacific residents in the facility. Staff described the ways that they ensure individual interests, customs, beliefs, cultural and ethnic backgrounds of Pacific residents are valued and fostered during service delivery. All family members are supported and encouraged to participate and have input in the day-to-day care of each resident. Staff interviewed understood the importance that Pacific people</p>

		<p>place on relationships with their family and the Pacific community.</p> <p>Cultural awareness training is provided to all staff when they commence employment and at ongoing intervals.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. It is completed at commencement of employment. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> <p>Interviews with caregivers and the registered nurse from the psychogeriatric and mental health unit confirmed their knowledge and practices to reduce discrimination and promote recovery. Residents described supportive relationships with staff. There was no evidence of denying access to support or treatment if residents refuse treatment.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>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, physiotherapist, wound care specialist, community dieticians, services for older people, psycho-geriatrician and mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education to support contemporary good practice. All RNs attend training on de-escalation strategies with the MidCentral District Health Board (MDHB) and have level four dementia qualification, plus the community mental health worker certificate.</p> <p>Other examples of good practice observed during the audit included all caregivers being trained in dementia care or in training, a comprehensive in-service training programme and two RNs on site have completed their masters of nursing with a focus on caring for the older adult. They are at present waiting confirmation from the New Zealand Nursing Council on their fulfilling the council's requirements for prescribing recognition. The GP interviewed verified his support in enabling this to occur. In addition good practice is promoted through the individualised focus of care planning and the highly regarded meal service that received a number of compliments.</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>Residents and family/whanau members stated they were kept well informed about any changes to their own or 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. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Residents and family/whanau members interviewed verified they were kept informed of the upcoming sale.</p>

		<p>Interpreter services can be accessed via 'language line' interpreting service when required and staff knew how to do so. Staff reported interpreter services were rarely required due to all present residents being able to speak English. A resident under the age of 65 years confirmed that staff communicated frequently and effectively, in ways that met their needs.</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 overall Bupa business plan and risk management plan outline the purpose, values, scope, direction and goals of the organisation. These are also on display throughout the facility. The facility manager provides weekly and monthly performance monitoring reports to the wider organisation and line management which includes any emerging risks and issues.</p> <p>The manager has been in the role for five years and was the clinical nurse manager at the facility for five years prior to that. The current clinical nurse manager has been in the role since 2007. Both are NZ registered nurses with current practising certificates. Responsibilities and accountabilities for these roles are defined in job descriptions and individual employment agreements. The care manager and clinical manager confirmed knowledge of the sector, regulatory and reporting requirements. There is evidence that each attend at least eight hours of professional development per annum and also regular forums with sector peers.</p> <p>The service holds contracts with Whanganui DHB and the Ministry of Health (MoH) for Young People with Disabilities (YPD). Broadview Care Home has a stated maximum occupancy of 85 residents. On the days of audit the psychogeriatric unit was full with 10 residents, the mental health unit had nine of its ten beds full, the dementia unit was full with 15 residents, nine of the 14 rest home beds and 22 of the 36 hospital level care beds were occupied. Two residents were receiving care under the young people with disabilities contract and another resident under 65 years was occupying an assessment bed. A younger resident with physical disability interviewed expressed satisfaction with the way services are provided. The younger residents' bedrooms are located within the hospital wing, this was not a concern for the person interviewed.</p> <p>The new provider is Heritage Lifecare Ltd (HLL) which is an established</p>

	<p>New Zealand aged care provider, currently operating more than 1100 beds in the sector. Two of their existing facilities provide for psychogeriatric services, and they acknowledge that although provision of mental health beds will be a new scope, members of their senior management team have extensive experience in auditing and contracting for these types of services. The current manager at Broadview who has extensive clinical and management experience in the provision of mental health services, was involved in the establishment of the MH unit nine years ago and has overseen the care provided as a clinical manager and now facility manager. The prospective provider and the current manager therefore know the regulations and standards related to mental health. Furthermore there is no intention to change what is already working well. HLL will be maintaining the arrangements that currently exist with BUPA (for example, regular meetings with the clinical mental health teams, including psychiatrist and District Inspectors for visits and clinical reviews and the relationship with the DHB portfolio manager.) HLL expect to be guided by the local mental health 'experts' in regard to safe and effective provision of mental health services for this consumer group.</p> <p>An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017) Broadview 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 providing information technology capability, including hardware and software. Regional workshops are planned to introduce documentation, and the new HLL 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 the facility and other existing staff will transfer to the new provider.</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, the clinical manager carries out all the required duties under delegated authority. The clinical manager's role is substituted by one of the senior registered nurses who are experienced in the sector and able to take responsibility for any clinical issues that may arise. Interviewees stated these arrangements work well and there were no issues last year when the clinical manager 'acted up' in the care manager's role for three months while the care manager was allocated to another facility.</p> <p>The prospective provider is not planning any staffing changes. Existing cover arrangements for the day to day operations will remain in place. The prospective provider 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 quality and risk system reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident and relative satisfaction survey, monitoring of outcomes, and clinical incidents including infections. The quality/health and safety plan contains site specific annual goals which are reported on quarterly. The 2017 goal of reducing staff injury by 50 % was achieved.</p> <p>A new shared electronic information management system (RiskMan) was introduced in late 2017 and all corrective actions, complaints, incidents and other quality and risk data is entered on to this.</p> <p>The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The policies reviewed covered 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.</p> <p>Meeting minutes confirmed regular review and analysis of quality indicators and that related information is reported and discussed at staff</p>

	<p>meetings. This includes bi monthly general staff meetings, monthly RN meetings, three monthly quality meetings with key service staff, and weekly clinical review meetings with the clinical care manager and the RN leaders from each wing. Internal audits of all areas of service delivery are occurring as per the timing in the annual audit schedule. There is evidence of changes to processes where a need for improvement is identified. Training is provided to all staff annually on the quality and risk management system (eg, incidents, accidents, complaints and hazards).</p> <p>The risk/hazard register is site specific and kept up to date with new hazards being added as required. Staff reported their involvement in quality and risk management activities through audit activities and discussion of results at meetings.</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. The nominated health and safety co-ordinator conducts environmental audits and provides an in depth orientation to new staff. The care manager and clinical manager support all staff with on the job training (such as moving and handling and de-escalation techniques) to prevent personal injury.</p> <p>Prospective Owner Interview</p> <p>During the transition phase, HLL's policies and procedures will be introduced. By the end of 2018, HLL's 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 HLL 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. It is not intended that</p>
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		the national clinical governance group will include mental health experts. HLLs model is to also have clinical governance in each region with membership from local clinicians who reflect the scope of the services being delivered.
<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>	FA	<p>All adverse and near miss events are entered into the electronic system on the day of the event. This alerts the manager and the clinical manager who review and investigate where indicated. Each incident is allocated a severity code by the registered nurse or clinical manager. The severity determines follow up actions. Where indicated an action plan is developed and the impact of the actions is monitored for effect. The service implemented a range of strategies in 2017 to reduce urinary tract infections and falls when comparison of data showed upward unwanted trends and rates that were above the organisation's key performance indicators. This resulted in some decreases. Changing to the electronic system in September produced different outcome reports and interfered with the site month by month comparisons, but new trending benchmarks are now in place. Site specific data is collated, analysed and reported monthly to the wider group and to staff. This provides key information for discussion at staff meetings.</p> <p>The managers understand essential notification reporting requirements and provided evidence of notifications of significant events made to the Ministry of Health, and/or the district health board since the previous audit.</p> <p>There are no known legislative or compliance issues impacting on the service.</p> <p>The prospective owner interviewed, is aware of all current health and safety legislative requirements and the need to comply with these. The interviewee was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.</p>
<p>Standard 1.2.5: Consumer Participation</p> <p>Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are</p>	FA	<p>There are effective systems for involving residents in evaluation of the service. The organisation's policy on consumer participation for mental health units describes the ways in which residents can participate in the service. Due to the impaired functioning level of the residents, their input</p>

<p>responsive to the needs of individuals.</p>		<p>is limited into planning and evaluation of the service. Resident surveys are completed annually and suggestion boxes are in place. Individual residents and family/whanau meetings occur every two to three months in each wing.</p> <p>Focus groups specifically for the mental health residents are held every six months. Residents, family members and advocate group for families attend. Residents, are involved in discussions, suggestions and compliments. Management informed the auditors that the minutes of these meetings are sent to all residents. The nurse manager attends service provider meetings at Balance NZ (local and national mental health consumer group) and Broadview Home and Hospital receive Balance NZ newsletters. Rather than regular group meetings, staff interviewed stated that there is a focus on a one to one meetings and impromptu meetings when required.</p> <p>There are no consumers working in the service as peers. However, the service does have a memorandum of understanding with the Balance peer support service. Family/whanau members who have enduring power of attorney, on behalf of the client have input into the service through satisfaction surveys, regular forums and informal feedback.</p> <p>The district inspector visits two to three times a year. Their contact details are posted on the noticeboard in the unit.</p>
<p>Standard 1.2.6: Family/Whānau Participation</p> <p>Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.</p>	<p>FA</p>	<p>The family/whanau and carer participation policy describes how the service receives feedback and input from family, such as surveys and evaluations. Family/whanau are invited to both the community residents and family/whanau meetings and the focus meetings. A family/whanau member set up a men's groups which is attended by men and women and managed by men. With residents' consent or enduring power of attorney, families/whanau/carers and/or significant others are asked to participate in the personal care planning process. Each resident's file contains information about contact with families, for example, the frequency of agreed contact, and for what purposes, and entries describing each contact. The six monthly focus meeting with management, families and residents encourages participation in service planning and evaluation. A representative from Mental Health Wellbeing and Support (MHWS -</p>

		<p>formerly Supporting Families) attends these meetings regularly. They also attend the community residents and family/whanau meetings from time to time as evidenced on the minutes. This representative gives a speech at the meetings to define their role. They do not sit on interview panels but informed the auditor that they would if invited to. Their job description is defined by MHWS. This representative has strong networks and works together with family members who have residents in the unit, when requested.</p> <p>A family member interviewed confirmed they are kept fully informed about the resident's progress and are encouraged to participate.</p> <p>The family advisor has left and a replacement has been found but not yet oriented to the job. Clear terms of reference for this role have been developed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Registers of practising certificates and current first aid certificates are maintained.</p> <p>A sample of staff records reviewed contained evidence of a recruitment process, signed employment contracts, completed orientation, and annual performance appraisals. Staff orientation includes all necessary components relevant to the role. New staff reported that the orientation process prepared them well for their role. A performance review with all new employees occurs three-months after commencement of work.</p> <p>Continuing education is planned on an annual basis and includes mandatory training requirements and as needed education using 'toolbox' talks. Clinical staff fulfil their professional development requirements by attending education provided by the District Health Board or other external courses. There are effective systems for tracking each staff member's attendance at mandatory training, such as fire and emergency training, and safe handling and transfers, and first aid and medicine competencies if that is a requirement of their role. Staff who work in the dementia and psychogeriatric unit have completed the required dementia standards, and</p>

		<p>a number of care assistants have completed the Mental Health Support Workers certificate.</p> <p>Seven of the thirteen employed RNs have completed interRAI training and are maintaining their competencies.</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>Staffing levels meet contractual requirements. There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The care home manager and clinical manager are registered nurses who are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week. There is at least one registered nurse on duty in the hospital wings at all times and another registered nurse 24 hours per day in the mental health and psychogeriatric units. A fulltime employed registered nurse oversees care in the rest home and dementia unit Monday to Friday until 4pm with the hospital RN's available if required during afternoon and night shifts. The facility adjusts staffing levels to meet the changing needs of residents or service demands. 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 sufficient staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of the previous four-week roster cycle confirmed adequate staff cover had been provided, with staff replaced in any unplanned absence.</p> <p>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 was able to confirm understanding of the required skill mix to ensure residents who require rest home, hospital, dementia, psychogeriatric and mental health care needs are met. The organisation already provides the range of levels of care (geriatric/medical, dementia, and rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services.</p>
Standard 1.2.9: Consumer Information Management Systems	PA Low	The resident's name, date of birth and National Health Index (NHI)

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Progress notes were legible, however the name and designation of the person making the entry was not 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, and specialist mental health services (SMHS) for residents of the secure unit and PG unit. Prospective residents and/or their families /whanau are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the clinical nurse manager (CNM). They are also provided with written information about the service and the admission process.</p> <p>Family/whanau members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p> <p>The eligibility criteria for the mental health unit requires that all residents have a community treatment order (CTO) in place. Each of the resident's files in the mental health unit had a current CTO.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the organisation's transfer system to facilitate transfer of residents to and from acute care services. There is open communication between all services,</p>

		<p>the resident and the family. At the time of transition between services, appropriate escorts, appropriate information including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</p> <p>The risks associated with transfer of a resident in the mental health unit to rest home level of care are currently being assessed and communicated to the parties involved.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for PRN medicines met. The required three monthly</p>

		<p>GP review is consistently recorded on the electronic medicine chart.</p> <p>There is one resident in the rest home who self-administers an inhaler medication at the time of audit. Processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and CNM and recorded on an accident/incident form. 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.</p> <p>Standing orders are not used.</p> <p>The psychotropic medicines in use are prescribed and monitored by the visiting psychiatrist/psychogeriatrician. There is evidence of communication between the psychiatrist and the GP in the resident's records.</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>The food service is provided on site by a cook 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. A food control plan has been registered 22 September 2017.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook 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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of residents' satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes.</p>

		<p>Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> <p>Residents in the PG and secure unit have access to food at all hours.</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>	FA	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC or SMHS is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC/SMHS is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission residents of Broadview Rest Home and Hospital are initially assessed using a range of nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, mini mental assessment screening and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require. Residents in the PG unit are visited by the psychiatrist each week and in the secure unit are assessed by a psychiatrist as needed. The GP visits the facility twice weekly and assesses residents three monthly or more frequently as deemed necessary.</p> <p>In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verified that the RNs are familiar with requirement for reassessment of a</p>

		<p>resident using the interRAI assessment tool when a resident has increasing or changing need levels, as evidenced in a resident transferring from PG to hospital level care and from mental health to rest home.</p> <p>All residents have current interRAI assessments completed by seven of eleven RN trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p> <p>Regular and ongoing assessment of the physical and mental wellness (by the visiting psychiatrist) of residents in the mental health unit, clearly identified ongoing and new needs. These are recorded in comprehensive care plans. Cultural assessments did not require input from tohunga or traditional healers. There is a required improvement in standard 1.3.5 related to ongoing assessment of mental health early warning signs and relapse prevention planning.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed. All residents have a 'map of life', identifying past lifestyle patterns, interests, jobs and family. In addition, there is a 'my way, my day' plan that describes the individualised routines and needs of the resident, and how these are to be met.</p> <p>Residents in the secure and PG unit in addition to the above, have a dementia care plan which identifies things that may upset the resident, and associated triggers, plus the things that calm the resident. The plan identifies risks associated with confusion/aggression and strategies to minimise these risks over a twenty-four hour period. Strategies for providing a low stimulus environment are in place in addition to a small quiet area to enable residents a place of low stimulation. Any form of restraint, specifically around "holding techniques" are used as a last resort. All start working in the unit, have attended training with the DHB around "safe hold techniques". Continuity of trained staff evidences staff who are well tuned to the needs to the resident. Input from the visiting psycho-geriatrician and psychiatrist was evident in residents' notes with assistance accessible from the community mental health nurse, the CNM or the organisation's dementia care advisor.</p>

		<p>Residents' records in the mental health unit identified early warning signs. One resident is undergoing assessment under section 13 and early warning signs and relapse prevention are still being identified. Evidence of the resident's involvement and agreement to their plans is confirmed by interview and their signatures on the plan. There is a requirement to ensure that relapse prevention strategies are individualised.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families / whanau reported participation in the development and ongoing evaluation of care plans.</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 of a high standard. 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>Staff work in cooperation with visiting mental health professionals and community groups to promote mental wellness, prevent relapse, reduce stigma and minimise the impact of mental illness.</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>	PA Low	<p>The activities programme is provided by a qualified diversional therapist (DT), and two activities officers, five and a half days a week. A full time DT works from 8.30am to either 4pm/5pm Monday to Friday. The two activity assistants work 10am-2.30pm, five days per week, however assist with lunches 12pm-12.30pm, and have their own lunch 12.30pm-1pm.</p> <p>One spends time in the secure unit from 1pm-2.30pm, or doing an activity elsewhere that includes residents of the unit. The other assists with activities in the hospital or rest home area and includes residents from all</p>

		<p>areas if they request to participate.</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 regularly and as part of the formal six-monthly care plan review and multidisciplinary review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. The activities plan includes a range of activities, occurring in each area. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included visits to the local cosmopolitan club, coffee bars, visiting entertainers, move and groove, church services, men's group - run by two men from the community, and gardening. Younger residents are able to participate in community interest groups as they choose. One resident is doing extramural studies, while another focuses on an interest in music. The activities programme is discussed at the residents' meetings and indicated residents/family/whanau input is sought and responded to.</p> <p>A holistic twenty four-hour approach to activities was observed in the documentation sighted in the PG and secure unit. Assessment on admission includes the 'map of life' and includes all aspects of the resident's life. The plan of care and activities focusses on 'my way, my day' and specifically details the resident's daily lifestyle patterns and routines to be followed, including the resident's interests.</p> <p>Minimal evidence was sighted of activities in the mental health, secure unit and PG unit being provided. Resident and family satisfaction surveys demonstrated some dissatisfaction with the activities programme. There is a requirement to review the resources and allocation of activities in dementia, mental health and PG units.</p> <p>Residents and family/whanau interviewed in the hospital/rest home confirmed they find the programme meets their needs,</p>
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<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 RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain, weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as the management of aggression, challenging behaviour, falls and wound management are evaluated each time the management regime is reviewed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>There are a range of outcome measures in use from the psychiatrist and clinicians who evaluate the ongoing mental health status of residents in the mental health unit.</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>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, 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 older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	<p>FA</p>	<p>All staff who handle chemicals have completed safe chemical handling training. This is a mandatory training subject. An external company is contracted to supply and manage all chemicals and cleaning products and provide staff with product information. Material safety data sheets were</p>

<p>harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Appropriate signage is displayed where necessary.</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>	<p>PA Low</p>	<p>A current building warrant of fitness expiring on 11 August 2018 was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Testing and calibration of hoists and medical equipment occurs regularly. The testing and tagging of other electrical equipment is carried out annually by an external contractor. The maintenance staff conduct weekly checks of equipment (hoists, wheelchairs) and carry out minor repair work. There is a preventative maintenance schedule which is adhered to. Staff confirmed they know the processes they should follow if any repairs or maintenance is required, and said requests are actioned in a timely manner. The internal environment is hazard free, residents are safe and independence is promoted.</p> <p>External areas are safely maintained, with the exception of the outside area in the dementia wing, where an improvement is required.</p> <p>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>	<p>FA</p>	<p>There are sufficient numbers of accessible bathroom and toilet facilities throughout the facility. This includes a number of bedrooms in the hospital and rest home wings with either a shared toilet facility or individual ensuite bathroom. Staff and visitors toilets are separately designated. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to</p>

		promote residents' independence. All areas are in good condition.
<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</p> <p>There is sufficient space to store mobility aids and wheel chairs. Residents and family expressed satisfaction with the 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 in each wing for residents to engage in activities. The dining and lounge areas are combined in each wing but these are large enough for the number of residents using them and are easily accessible for residents. There are additional smaller lounges in each wing for privacy or family meetings when required. Furniture is appropriate to the setting and residents' needs</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry staff are on site seven days a week. These staff have been provided with training in safe handling of chemicals and general health and safety education, as confirmed in interview with staff and training records. All areas in the facility are clean and hygienic. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Staff clearly described safe and effective processes for ensuring all areas in the facility are clean and a dirty/clean flow and handling of soiled linen. Relatives interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	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 described the procedures to be followed in the event of a fire or other emergency.</p>

		<p>The current fire evacuation plan is approved by the New Zealand Fire Service. Trial evacuation drills occur every six months, the most recent was 30 August 2017. Records show 100% of staff attended at least one trial evaluation last year. The orientation programme includes fire and security training.</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 maximum number of residents (85). Portable water is stored and there is a backup battery on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. These were tested on the day of audit and staff responded within a reasonable time.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All rooms have natural light and opening external windows. Heating is provided electronically via a central system which has individual controls in residents' rooms and in the communal areas. The air conditioning vents in the main corridors of each wing were not fully effective in spreading cool air through to bedrooms and the smaller lounges in Kauri and Kowhai during a heat wave on the days of audit. However, internal temperatures recorded at the time were not above 25 degrees Celsius, the temperature setting was turned down and portable fans were ordered. Residents and families interviewed said the facilities are maintained at a comfortable temperature during all seasons.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>PA Negligible</p>	<p>Broadview Rest Home and Hospital provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. The programme is developed by the organisation's quality and risk team, with input from each facility's infection control officers (ICO), external advisors and the national health and safety co-ordinator. Infection control management is guided by a comprehensive and current infection control manual. The infection control policies have been</p>

		<p>reviewed in the past two years; however, the programme has not been reviewed annually and was last reviewed in October 2016.</p> <p>The CNM is the designated ICO, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CNM and tabled at the two-monthly quality, staff, health and safety and infection control meetings. Immediate concerns are managed daily and handed over at shift changes. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. Information is then fed back to the facility.</p> <p>The organisation's quality/risk manager receives a written report monthly from the facility and is informed immediately of any IPC concern.</p> <p>Signage at the main entrance to the facility over winter requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICO has appropriate skills, knowledge and qualifications for the role. The ICO has undertaken post graduate training in IPC and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICO confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and</p>	FA	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following</p>

<p>are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was 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 infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICO. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.</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>	<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 in the resident's clinical record. New infections and any required management plan are discussed at handover to ensure early intervention occurs.</p> <p>A recent influenza outbreak occurred in September 2017, and evidence was sighted of liaison with public health services. Staff uptake of flu vaccinations has improved since the previous year by 35%. A number of residents of the PG and secure unit are unwilling to have flu vaccinations despite ongoing education.</p> <p>The ICO and CNM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative</p>

		<p>factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, 21 residents were using restraints, the majority of these being lap belts, low-low beds and bed rails. Enablers were being voluntarily used by three residents. A comprehensive assessment and management process is followed for the use of both enablers and restraints, which ensures the on-going safety and wellbeing of the resident.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval form in files of residents with restraints currently, and from the interview with the restraint coordinator</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</p>	FA	<p>The restraint co-ordinator, together with another registered nurse, and the resident and/or family whanau, are involved in the restraint approval process. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the restraint coordinator and</p>

<p>and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>clinical nurse manager that there are clear lines of accountability, that only approved restraints/enablers are in use, and that the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in decision making, as is required by the organisation's policies and procedures, was sighted in the care plans reviewed of residents using restraints or enablers.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The initial assessment is undertaken by a registered nurse working with the restraint coordinator, together with resident's family/whānau/EPOA involvement. The restraint coordinator described the documentation process. This process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of three residents who were using a restraint. A family member confirmed their involvement in the restraint assessment process.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The restraint coordinator and the clinical nurse manager discussed the strategies that had been implemented to actively minimise the use of restraint. Consideration is also being given to developing a quality initiative in the near future in relation to further minimising the number of restraints currently being used.</p> <p>The restraint coordinator described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and trialling suitable alternatives, such as the use of sensor mats, before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe as per the resident's care plan. Records contain the necessary details, access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. This is included in the resident's care plan and monitoring forms reviewed recorded that this had occurred as required.</p> <p>A restraint register is maintained, updated every month and reviewed at</p>

		<p>each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Training in restraint minimisation and safe use of restraints is a compulsory education requirement for all care delivery staff. Staff are also required to complete a restraint-related worksheet annually, and registered nurses and senior caregivers must also annually demonstrate competency related to restraint management.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files confirmed the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. A family member confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation includes all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint coordinator completes a monthly report related to restraints and enablers, which is then entered into the organisation's key performance indicators database, and benchmarked with other facilities within the group. The organisation holds a restraint meeting quarterly. The facility has its own three-monthly restraint meeting, the results of which are circulated to staff, and also reported to the quality committee (minutes sighted). Those minutes revealed a thoughtful evaluation of restraint/enabler use, and any associated staff education or safety issues.</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 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	<p>PA</p> <p>Moderate</p>	<p>Five of the six residents' records reviewed in the mental health unit had 'not for CPR' orders signed by the general practitioner. The forms deemed the residents to be incompetent despite the majority of these people having agreed to and signed off other consents including their care plans. Section 151 of the Crimes Act 1961 provides that where someone "has charge" of another person, who is unable to withdraw him or herself from such charge, and to provide him or herself with the necessaries of life, there is "a legal duty to supply that person with the necessaries of life". Furthermore Right 7(5) and 7 (7) of the Code of Health and Disability Services Consumers' Rights ("the</p>	<p>Residents' records and interviews could not evidence that discussion about CPR or NFR with residents (or their nominated representatives) in the mental health unit, had occurred prior to the general practitioner signing off not-for-resuscitation advance directives.</p>	<p>Ensure that not for CPR orders are discussed and signed off by the resident or that in the case of medically-initiated DNR orders there is evidence the resident and/or the family have been informed or that attempts have been made to inform them.</p> <p>90 days</p>

		Code”) determines that the right to refuse CPR must be exercised by the patient: it cannot be delegated to a proxy. While medically-initiated DNR orders do not require the patient’s consent, best practice DNR policies require health practitioners to record that the patient has been informed, or that an attempt has been made to do so.		
<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	PA Low	In all files reviewed the progress notes are legible, however in eight of ten files reviewed in the secure and PG units the name of the person making the entry was illegible and the designation was not always recorded.	The name and designation of the person making entries into the progress notes is not legible, and the designation is not consistently recorded.	<p>Provide evidence all records are legible and the name and designation of the service provider is identifiable.</p> <p>180 days</p>
<p>Criterion 1.3.5.4</p> <p>The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate.</p>	PA Low	Review of resident records (in the crisis point assessment), revealed that the relapse prevention strategies are not linked to an individual’s early warning signs or their care plans, nor are they personalised. The strategies are not resident focused, but rather they described actions for staff to take. Interview with the RN and clinical care manager revealed these had been developed by a previous RN and subsequent review of these had not identified this. It is also noted that the early warning signs have not altered since the residents’	The relapse prevention strategies in each of the resident’s crisis point assessment records are the same. These do not correspond to the resident’s documented early warning signs and are not reflected in or linked to care plans. The annual review of each resident’s crisis point assessment including early warning signs has not resulted in any documented changes.	<p>Review and update each mental health resident’s crisis assessment point, specifically their early warning signs and relapse prevention plans. Ensure these accurately reflect the individual and link these to their care plans.</p> <p>180 days</p>

		admissions; some have been living in the unit for more than five years.		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>The activities programme is provided by a qualified diversional therapist, and two activities officers, five and a half days a week. A full time DT works from 8.30am to either 4pm/5pm Monday to Friday. The two activity assistants work 10am-2.30pm, five days per work, however assist with lunches 12pm-12.30pm, and have their own lunch 12.30pm-1pm. One spends time in the secure unit from 1pm-2.30pm, or doing an activity elsewhere that includes residents from the unit. The other assists with activities in hospital or rest home area and includes residents from all areas if they request to participate.</p> <p>Minimal evidence is sighted of activities in the mental health, secure and PG unit being provided by activities personnel and this is verified by staff, residents and family interviews. Care staff are required to provide the activities, with a range of resources available for them to do so. Interview with the DT identifies residents from the secure and PG unit are able attend the "united" activities programme in other areas of the facility if they choose.</p> <p>Resident and family satisfaction</p>	There are insufficient activities (either group or one on one) provided in the mental health, PG or secure units.	<p>Provide evidence of a review of the allocation and implementation of the activities programme to ensure the programme facilitates the strengths, skills and interests of all residents.</p> <p>180 days</p>

		surveys demonstrated some dissatisfaction with the activities programme.		
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	PA Low	<p>Inspection of the external areas in the dementia unit identified an unsecured shed door which houses the motor for the water system. This was rectified and made secure on audit day. The perimeter is surrounded by pool fencing with upward bars that are approximately 12cm width apart. This allows residents to see out but is of concern for safety and security reasons. A resident was able to get out three times by loosening and replacing the bars before the breach was identified and made secure by fixing panel boards in that area. This rest of the fencing needs to be considered. There are uneven surfaces on the walkway leading up to the water tanks which pose a tripping hazard. There have been no falls in this area to date.</p>	<p>The openness of the pool fencing surrounding the dementia unit can provide an inducement for confused people to try and get through or over the fence.</p> <p>Uneven surfaces in the concrete walkway pose a tripping hazard.</p> <p>The unsecured door of the water system shed had not previously been identified as a risk.</p>	<p>Ensure that all areas outside the dementia unit are always maintained as safe, secure and appropriate for the people who access them.</p> <p>90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Negligible	<p>The organisation has a clearly defined IPC programme, developed at organisational level by the quality and risk team. The policies are evidenced to have been reviewed in the last two years and compliance with the programmes implementation at Broadview Rest</p>	<p>The infection control programme has not been reviewed within the last year.</p>	<p>The infection control programme is reviewed annually.</p> <p>180 days</p>

		<p>Home and Hospital was sighted. There is no documentation to verify the programme has been reviewed annually. This finding is verified by interviews with the ICO and documentation from the organisation's quality management co-ordinator. The organisation has documented its commitment to reviewing the programme prior to the end of March 2018.</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.