

Heritage Lifecare Limited - Carter House

Introduction

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

The audit has been conducted by 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:

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| Legal entity: | Heritage Lifecare Limited |
| Premises audited: | Carter House |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 23 January 2018 End date: 24 January 2018 |
| Proposed changes to current services (if any): | None |
| 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.

Key to the indicators

| Indicator | Description | Definition |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |

| Indicator | Description | Definition |
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| Yellow | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
| Red | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

General overview of the audit

Carter House Lifecare provides rest home, dementia and hospital geriatric level care for up to 65 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

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

The audit has resulted in two areas identified as requiring improvement relating to staff education and care planning for residents in the dementia service.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | Green | Standards applicable to this service fully attained. |
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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.

The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively. One Health and Disability Commissioner (HDC) complaint currently remains open, however it is noted that this relates to events which occurred prior to ownership by Heritage Lifecare limited (HLL).

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of low risk. |
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Heritage Lifecare Limited is the governing body and is responsible for the services provided at this facility. A business and quality and risk management plans are documented and include the scope, direction, goals and values and mission statement of the

organisation. Systems are in place for monitoring the services provided, including regular weekly and monthly reporting by the facility manager to the organisation's support office. The facility is managed by an experienced and suitably qualified manager who is a registered health professional.

A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection prevention and control, restraint minimisation and safe practice and resident, staff and family/whanau satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported at the quality and staff meetings, with discussion of trends and any follow-up where necessary. Meeting minutes, graphs of clinical indicators and benchmarking results are displayed. Adverse events are documented and are seen as an opportunity for improvement. Corrective action plans are being developed and implemented, monitored and signed off once completed electronically. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up-to-date.

A suite of policies and procedures cover all necessary areas, were current and have been implemented since the last audit. The human resources management policy guides the system for recruitment and appointment of staff. Orientation and ongoing education is provided to all employed staff and a record is maintained in the staff member's individual record.

Staffing levels and skill mix meet contractual requirements and the interRAI assessments influence the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using an integrated hard copy file.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers, the clinical leads report and handover sheets guide continuity of care.

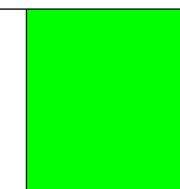
Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. 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 residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

The food service meets the nutritional needs of the residents with special needs 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 overall satisfaction with meals.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |
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The facility has been purpose built. There are single rooms including some with ensuite bathrooms, all of adequate size to provide personal care.

All building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemical, soiled linen and equipment are safely stored. All laundry is undertaken on site, with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to an emergency power source is available. Residents report a timely staff response to call bells. A contracted security company monitors the facility each night.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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The organisation has implemented policies and procedures since the last audit that support the minimisation of restraint. One enabler and three restraints were in use at the time of the audit. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and annually, including all aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |
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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 Bay of Plenty District Health Board, an external advisory service and the organisation's national quality and risk manager. The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, with data 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 | 48 | 0 | 1 | 1 | 0 | 0 |
| Criteria | 0 | 99 | 0 | 1 | 1 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Carter House 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> | FA | <p>Nursing and care staff interviewed understand 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 (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. All</p> |

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| | | <p>resident files reviewed in the secure unit had an EPOA in place.</p> <p>Staff were observed to gain content for day to day care on an ongoing basis.</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. Brochures related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. An independent advocate runs the monthly residents' meetings. The residents' advocate was unavailable for interview at the time of audit.</p> <p>Staff were aware of how to access the advocate and 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.</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> | FA | <p>The concerns/complaint/compliment policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents/family members on admission and there are complaints information and forms available in a number of areas in the facility.</p> <p>The complaints register reviewed showed that two complaints have been received since the last audit and that actions taken, through to an agreed resolution were clearly documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>There is one Health and Disability Commissioner's complaint/coroners case from 2015 which is still open. It is noted that this relates to events which occurred prior to ownership by HLL. All information was able to be tracked in the register and correspondence reviewed was current and up-to-date. Heritage Lifecare Limited is currently awaiting a further response from the HDC office, as correspondence is managed by the organisation's support</p> |

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| | | office. |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information, visits by the advocacy service to residents' meetings 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>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Evidence verified 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 providing privacy when exchanging verbal information. 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, except for the residents' cultural needs, referred to in criterion 1.3.5.2.</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 is one resident in Carter House at the time of audit who identifies as Māori. Interviews and observation verified the resident is supported by staff to integrate their cultural values and beliefs. Documentation however does not address the resident's cultural needs (refer criterion 1.3.5.2). 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 cultural advisers.</p> |

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| <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> | <p>FA</p> | <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> | <p>FA</p> | <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 the commencement of employment. Ongoing education is also provided, however this has not always been completed. (refer criterion 1.2.7.5). 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>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, physiotherapist, wound care specialist, psycho-geriatrician and mental health services for older persons, and education of staff. The GP and a clinical nurse specialist (CNS) (via phone interview as the GP she worked with was on leave), 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 to access external education opportunities (eg, DHB training sessions).</p> <p>Other examples of good practice observed during the audit included all caregivers either trained or completing the training to care for residents with dementia, caregivers and RNs trained in palliative care, the GP providing</p> |

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| | | the staff with links to ongoing education sites, and a staff committed to providing residents with quality care. |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and 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>Interpreter services can be accessed through Bay of Plenty District Health Board (BOPDHB). Staff knew how to do so. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe the annual and longer term objectives and site specific objectives and the associated operational plans. The facility manager provides a weekly and monthly report against the objectives to the organisation's support office. A sample of reports reviewed showed adequate information to monitor performance is reported including emerging risks, complaints and/or issues.</p> <p>The service is managed by a facility manager who has been in the position since November 2017. The facility manager has relevant qualifications and skills for the role, is a senior registered nurse with previous aged residential care experience and holds a Bachelor of Nursing. In addition, the facility manager has had extensive law administration experience. The job description and the individual employment agreement reviewed on-line is kept at the organisation's support office. The national quality manager, on site at the audit, was able to access this information. The facility manager interviewed confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through on-going education. The facility manager is supported by the clinical services manager. Both attended the organisation's annual conference for managers in November 2017.</p> |

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| | | <p>The service holds contracts with the BOPDHB for Aged Related Residential Care (ARRC) rest home, dementia and hospital geriatric level care services, respite care, palliative care, and the Ministry of Health (MOH) for people under 65 years.</p> <p>On the day of audit, 64 residents were receiving services; 23 residents were receiving rest home care, 24 hospital and 17 dementia care. All 64 residents receiving rest home and dementia care were under the Age Related Residential Care Contract. The 24 residents receiving hospital level care were under the Age Related Hospital Services Contract.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | FA | <p>When the facility manager is absent, the clinical services manager carries out all the required duties under designated authority with support from the regional operations manager and support office personnel. Staff reported the current arrangements work well.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>The organisation has a quality and risk management system that reflects the principles of continuous improvement and was understood by staff. This includes management of incidents and complaints, audit activities, an annual satisfaction survey, monitoring of outcomes, clinical incidents, interRAI, restraint minimisation and safe practice and infection prevention and control.</p> <p>Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs monthly and related information is reported and discussed at the one meeting which covers quality/staff/infection prevention and control/restraint meetings. Minutes reviewed include discussion on pressure injuries, falls, complaints, incidents/events, infections, audit results and activities. Relevant corrective actions are developed on a plan and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Resident and family surveys are completed annually (last completed July 2017). Surveys are distributed by the support office, with information sent back to the facility manager for ongoing evaluation and monitoring. Progress reports dated December 2017 were reviewed and information on outcomes had been collated and sent back to the support office to the</p> |

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| | | <p>national quality manager. A staff survey was performed July 2017.</p> <p>Policies and procedures cover all necessary aspects of the service and contractual requirement and are current. The document control system is managed by the organisation`s support office and ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of any obsolete documents. Heritage Lifecare Limited has implemented Heritage Lifecare Limited policies and procedures since the previous audit.</p> <p>The national quality manager described the processes for the identification, monitoring and reporting of risks and development of any mitigation strategies. The risk register showed consistent review and updating of risks, risk plans and the addition of any new risks identified. The facility manager is aware of the Health and Safety at Work Act (2015) and requirements have been implemented.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these are fully completed, incidents are investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the support office and meeting minutes reviewed showed discussion in relation to any trends identified, action plans and any improvements made.</p> <p>Policy and procedures described essential notification reporting requirements (eg, pressure injuries, health and safety issues, infections, the coroner and any HDC complaints). The clinical services manager advised there had been one infection outbreak (05 October 2017) since the previous audit. The GP interviewed was fully informed of any obligations in relation to essential notifications.</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>PA Low</p> | <p>Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of records are systemically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role.</p> |

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| | | <p>Staff reported that the orientation process prepared them well for their role and included support from another staff member in the same role during the initial orientation period. Staff records showed completed orientation and a performance review after a three month period and annually. Appraisals were current for all staff.</p> <p>There was an educational plan for 2017. Records were sighted such as a staff competency register inclusive of mandatory training requirements and a separate record of New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. Care staff have either completed or are enrolled in the NZQA education programme. Staff working in the dementia care area have completed the required training. Education records were discussed with the registered nurse responsible for education. The education records reviewed were incomplete. There are four registered nurses who are trained to undertake interRAI assessments. Staff records reviewed demonstrated completion of scheduled training up to August 2017.</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> | <p>FA</p> | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents using the indicators for safe aged care and dementia care services hand book. The care staff level is influenced by the interRAI assessments being completed.</p> <p>An after-hours on-call roster system is in place, with staff reporting that good access to advice is available when needed. When interviewed, the general practitioner for the facility reported that they are contacted after hours when necessary and all other appropriate action has been taken by the rostered and on-call staff.</p> <p>Care staff interviewed reported there is adequate staff available to complete the work allocated to them. Residents and families interviewed supported this. Observations and review of the two weekly rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week registered nurse coverage for the hospital level residents.</p> |

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| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | <p>FA</p> | <p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</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. Residents in the secure unit have additionally been assessed by specialist services. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the clinical services manager (CSM). They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | <p>FA</p> | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the BOPDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records 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</p> |

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| | | managed in a planned and co-ordinated manner. |
| <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> | FA | <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 GP review was consistently recorded on the electronic medicine chart.</p> <p>There was one resident who self-administers medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and CSM 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 used and meet the guidelines.</p> |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | FA | The food service at Carter House is provided on site by a qualified chef and |

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| <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | | <p>is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in May-2017. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. 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. Interview with the FM, identified the recently appointed chef has referees verifying training in safe food handling; however documentation verifying this has not yet been provided to the FM.</p> <p>A food control plan has been registered with the council 19 December 2017.</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 resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion. There were sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | <p>FA</p> | <p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CSM. 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>FA</p> | <p>On admission, residents of Carter House are initially assessed using a</p> |

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| <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | | <p>range of nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and a 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 a resident's changing condition requires.</p> <p>In all files reviewed, initial assessments were 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. All residents' files reviewed have current interRAI assessments completed by three trained interRAI assessors on site.</p> |
| <p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>PA Moderate</p> | <p>Plans reviewed reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information, in particular, the needs identified by the interRAI assessments, with the exception of some areas of the service delivery plans for residents in the secure unit.</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 reported participation in the development and ongoing evaluation of care plans.</p> <p>The care plans for residents in the secure unit did not always describe the required support to achieve the desired outcome.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their overall needs. The attention to meeting resident's generalised needs was evident in the care plan, however the specialised needs of some aspects of resident's care in the secure unit was not consistently well documented (refer criterion 1.3.5.2). The relieving GP and the CNS/trainee nurse practitioner for the GP (at present on leave), 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</p> |

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| | | provided and in accordance with the residents' needs. |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The activities programme is provided by a trained diversional therapist assisted by three activities co-ordinators, one of whom has nearly completed the diversional therapy training. The activities programme operates seven days a week in the secure unit and five days in the hospital and rest home.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Interviews and observation evidence activity assessments for residents in the secure unit include consideration of resident's twenty-four-hour activity needs, and activities are provided from 12 midday until early evening. The consideration of the residents' twenty-four-hour needs was verified by interviews; however this was not documented in three of four care plans reviewed in the secure unit (refer criterion 1.3.5.2).</p> <p>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 three/six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include caring for the pet rabbit, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Residents' 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</p> |

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| | | <p>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 wound management plans, were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>Behaviour management strategies implemented each duty for residents in the secure unit are evaluated each shift and recorded in the progress notes, however there is no overall management plan (refer criterion 1.3.5.2).</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 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 harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>Documented processes for the management of waste and hazardous substances were in place, including segregation of waste, recycling and detailing procedures for blood and bodily fluids management and disposal.</p> <p>Chemicals were seen stored in locked areas around the facility. Appropriate staff have undertaken training in chemical management.</p> <p>An external company is contracted to supply and manage the majority of chemicals used for cleaning and the laundry. The company provide relevant training for staff and a monthly report, a sample of which was sighted. Material data sheets were available for the chemicals provided by the external company and these are stored safely. Staff interviewed knew what to do should any chemical spill/event occur and stated they would report any related incidents in a timely manner.</p> |

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| | | There is provision and availability of protective clothing and equipment and staff were observed using this, including gloves, masks, face shields and plastic aprons/hats. |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>A current building warrant of fitness expires 29 November 2018 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to a high standard. The testing and tagging of equipment and calibration of bio medical equipment was current as confirmed in the documentation reviewed, interviews with maintenance personnel and observation of the environment.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. The environment was hazard free and residents were safe. Residents and staff interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, that any requests are appropriately actioned and that they are happy with the environment.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>There is a mix of toilet, showers and bathing facilities. This includes rooms with ensuites (eight rooms in the hospital wing), shared bathrooms between rooms, communal bathrooms and staff designated facilities. There is adequate numbers of accessible bathrooms and toilets throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | <p>There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photographs, paintings, ornaments and other personal items displayed.</p> <p>There is adequate room for use of sling/transfer and standing hoists to be utilised by staff for transferring residents to bed or to the chair. Mobility scooters have a designated parking area when not in use and for charging</p> |

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| | | the batteries as needed. |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>Communal areas are available for residents to engage in activities. One of the activities rooms has raised bowls with much space around so that residents can watch when a game is in progress if they wish to do so. There are large lounges and dining rooms in the rest home and hospital service areas which enable easy access for residents and staff. Furniture is arranged in a manner which enables residents to mobilise freely. There are two small dining rooms attached together for the residents in the dementia service. The dining rooms are used for the activities programme to be implemented.</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>All laundry is undertaken on site in a designated laundry. Resident's personal items are laundered on site or by family members if requested. Residents/family interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently washed by dedicated laundry staff who when interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Product and material data sheets are displayed and can be readily accessed as required. Personal protective resources are available at all times.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff have completed the New Zealand Qualifications Authority Certificate in Cleaning (Level 2) or other recognised training as confirmed at interview with cleaning and laundry staff. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and the contracted provider.</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 and response and were displayed and known to staff. The current fire evacuation plan was approved by the New Zealand Fire Service on the 27 February 2001. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent being the 14 December 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the</p> |

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| | | <p>emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas barbeque were sighted and meet the requirements for the 64 residents. Water storage tanks are located around the complex and there is a generator available if needed. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security measures are in place. Doors and windows are locked automatically at a predetermined time and a check of doors and windows is completed by oncoming staff in the evenings and night. The external door are alarmed. A contracted security company checks the facility during the night and the contractor signs the contractor's book. There is CCTV in all public areas and signage in relation to this was sighted at the entrance to the facility.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All residents' rooms and communal areas have opening external windows and natural light. Gas heating is provided with radiators in individual rooms and in the hallways. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities were well maintained at a comfortable temperature. There is one air conditioning unit and this is located in the kitchen.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the infection control co-ordinator (ICC). The infection control programme and manual are reviewed annually; due next March-2018.</p> <p>The quality co-ordinator at Carter House is the designated ICC, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CSM and FM and tabled at the staff, RN and quality/risk meetings. Infection control statistics are entered in the organisation's electronic database and</p> |

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| | | <p>benchmarked with the organisation's other facilities. The organisation's national quality and risk manager is informed of any IPC concerns.</p> <p>Signage at the main entrance to the facility and reception 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 ICC has appropriate skills, knowledge and qualifications for the role, and has undertaken training in infection prevention and control 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 an external advisor 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 ICC 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 are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, 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> | FA | <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 IPC education sessions (refer criterion 1.2.7.5.). Education is provided by suitably qualified RNs and the ICC. 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</p> |

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| | | <p>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 and providing ice blocks during hot weather.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Surveillance is appropriate to that recommended for long term care facilities, 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>The ICC reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via 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>A norovirus outbreak in September 2017, involved 19 residents and 16 staff. A documented analysis of the outbreak identified the outbreak was well managed, promptly responded to and contained within a confined area of the facility. No areas were identified as requiring corrective actions.</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 appointed to this role two weeks ago will provide additional support and oversight for enabler and restraint management in the facility. The clinical services manager has been in this role in the interim period and demonstrated a sound knowledge of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the day of audit, three hospital level care residents were using restraints</p> |

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| | | <p>and one enabler was in use, which were the least restrictive and used voluntarily at the individual resident's request. A similar process is followed for the use of enablers as is used for restraints. This provides for a robust process 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 group minutes and records reviewed of those residents who have approved restraints and from interviews with staff.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | FA | <p>The restraint approval group, made up of the clinical services manager the registered nurse restraint coordinator and the general practitioner, are responsible for the approval of the use of restraints and the restraint processes, as defined in policy. It was evident from review of restraint approval group meetings, review of each resident's records and interview with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family involvement in the decision making as is required by the organisation's policies and procedures, was on record in each case. Use of restraint or an enabler is included in the care planning process and documented in the lifestyle care plan.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA | <p>Assessments for the use of restraint were documented and included all requirements of the Standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator's involvement, and input from the resident's family/whanau/EPOA. The registered nurse interviewed/restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner has involvement in the final decision on the safety of the use of the restraint. The assessment process identified the underlying aetiology, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p> |
| <p>Standard 2.2.3: Safe Restraint Use</p> | FA | <p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family</p> |

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| <p>Services use restraint safely</p> | | <p>members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as the use of sensor mats and low beds are used before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe at all times. Records reviewed 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 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>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours and the mandatory annual restraint questionnaire competency was completed April 2017. Staff spoken to understood that the use of restraints was to be minimised and how to maintain safe use was confirmed.</p> |
| <p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p> | <p>FA</p> | <p>Review of residents' records evidenced the individual use of restraints is reviewed six monthly and evaluated during the lifestyle care plan and interRAI reviews six monthly and at the restraint approval group meetings. Families interviewed 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 Services demonstrate the monitoring and quality review of their use of restraint.</p> | <p>FA</p> | <p>The restraint committee undertakes a six monthly review of all restraints use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of the restraint is reported to the quality and staff meetings. Minutes of meetings reviewed in the restraint folder confirmed and included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the GP, staff and families. A</p> |

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| | | <p>six monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes of meetings and interviews with the clinical services manager and registered nurses confirmed that the use of restraint has been minimised. Graphs are documented which evidences the low rate of restraint use at this facility.</p> |
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Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | PA Low | The staff education records were reviewed along with the annual competency and mandatory training requirements to be completed as per the annual training plan documented for 2017. The registered nurse educator was interviewed and explained the education plan and progress since the previous audit. The records had not been updated since August 2017 and no plan was developed and/or implemented for 2018. | The organisation`s education policy has not been fully implemented and there is no evidence that staff have received the required education from August 2017 until January 2018. No education plan has been developed and implemented for 2018. | <p>Implement the organisation`s education policy requirements, ensure education is recorded accurately, and develop and implement an education plan for 2018.</p> <p>180 days</p> |
| <p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | PA Moderate | Four of four files reviewed of residents in the secure unit, had incomplete documentation to describe the full support the resident required to meet their assessed needs. Two of four residents reviewed had no plan in place to manage and monitor the residents` episodes of challenging behaviour. One of the two residents mentioned had recently been admitted. Episodes of challenging behaviours | The documentation detailing the support required by each resident in the secure unit, did not always fully describe each residents required needs. | <p>Provide evidence that the documentation for residents in the secure unit, is consistent with meeting the residents` needs.</p> <p>30 days</p> |

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| | | <p>had presented, and specialist input sought; however, no plan is documented to record specific medication management strategies implemented by specialist advisors or to monitor the effectiveness of the strategies. Interviews with staff described the de-escalation strategies being used to manage the resident's behaviour. The strategies are generic and not related to the particular needs of this resident based on a comprehensive behaviour assessment by the RN.</p> <p>A resident who identified as Maori, had no plan in place to meet the resident's cultural needs. Interviews with the family verified the resident was likely to resort to speaking in Maori, when the dementia progressed and verified they had not been consulted on the cultural aspects of care. They did however express a high level of satisfaction with the care provided at Carter House.</p> <p>A resident with a remission of heart failure had no documentation in place to monitor a recent increase in diuretic medication.</p> <p>Three of four residents' files had no documentation to address the residents' activity needs over the twenty-four-hour period (referred to Standard 1.3.7).</p> <p>Interviews and observation verified care staff are consistently monitoring and addressing all aspects of resident's needs. Two other family members available for interview, expressed satisfaction with the care provided at Carter House.</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.

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End of the report.