

Heritage Lifecare Limited - Coldstream 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:

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| Legal entity: | Heritage Lifecare Limited |
| Premises audited: | Coldstream Rest Home & Hospital |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 10 May 2018 End date: 11 May 2018 |
| Proposed changes to current services (if any): | Change of provider |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 53 |

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

Coldstream Rest Home & Hospital provides rest home and hospital level care for up to 58 residents. The service is operated by a company and managed by a clinical nurse manager and a clinical leader. Residents and families spoke positively about the care provided.

This facility is being sold and this provisional audit is being undertaken to establish the prospective owner's preparedness to provide a health and disability service and the current level of conformity with the required standards. A sale and purchase agreement with the prospective provider, Heritage Lifecare Limited, is anticipated to be enacted in June 2018. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, contracted allied health providers and general practitioners and a representative for the prospective provider.

This audit has resulted in areas requiring improvement relating to testing of equipment and care plan reviews.

Consumer rights

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

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

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

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

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

There is a complaints process that is understood by residents, family members and staff and meets the requirements of the Code. A complaints register is maintained with written complaints addressed 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 identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

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

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

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

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

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

Food is prepared and delivered on site and meets the nutritional needs of the residents with special needs catered for. Policies and procedures guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and met food safety standards. Nutritional assessments and dietary profiles had been completed on admission. Choices are available, and resident's nutritional need are identified, documented and provided for. Residents and their family/whanau verified satisfaction with the meals provided.

Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and offsite and evaluated for effectiveness.

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

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Four enablers and two restraints were 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 sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

The infection prevention and control programme, led by an appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the monthly quality assurance meeting which includes infection control. Specialist infection prevention and control advice is accessed from the district health board (DHB), microbiologist and infectious diseases physician. 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.

Infection surveillance is being undertaken, with results reported through all levels of the organisation. Any recommended follow-up actions are taken when indicated.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| Standards | 0 | 48 | 0 | 1 | 1 | 0 | 0 |
| Criteria | 0 | 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) |
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| 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> | <p>FA</p> | <p>Coldstream 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). Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in the most recent training day records - April 2018.</p> <p>Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options to residents and maintaining dignity and privacy.</p> <p>Residents and their family/whanau confirmed during interview that staff uphold the Code through speaking respectfully at all times, being aware of their need for privacy, encouraging them to make choices, maintaining their independence and involving family/whanau.</p> |
| <p>Standard 1.1.10: Informed Consent</p> | <p>FA</p> | <p>The clinical nurse manager, clinical leader, registered nurses and care</p> |

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| <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> | | <p>staff interviewed reported an understanding of the principles and practice of informed consent, and training occurs at orientation and yearly, as sighted. Informed consent policies and procedures provide relevant guidance to staff.</p> <p>Clinical files reviewed showed that informed consent has been gained appropriately. A section in the organisation's service agreement covers standard consent for use of personal information. The clinical leader explained how this is described to the resident and often a family/whanau member if present, prior to or on admission and time is given to ensure the documentation is understood before signing it. Separate signed consent forms were sighted in records including recent influenza vaccinations and outing indemnity.</p> <p>Advance care planning documentation and the establishment and documenting of enduring power of attorney requirements (EPOA) and processes for residents unable to consent is defined and documented where relevant in the resident's record, as sighted. Residents' records noted when a resident does not have or has chosen not to have an EPOA. The clinical leader demonstrated her understanding of these situations by being able to explain different situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis which residents, family/whanau confirmed consistently occurs on a daily 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> | <p>FA</p> | <p>During the admission process, residents are given a copy of the Code which also includes information on the Advocacy Service. In addition, posters on consumer rights which also contain information related to the advocacy service were displayed at the entrance to the facility and additional brochures were available at reception. There is a copy of the Code in every resident's room in the facility and observed in residents' rooms during interviews.</p> <p>The residents and two family/whanau members interviewed were aware of the advocacy service, how they would access this and their right to have a support person, however had had no need to use the service so</p> |

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| | | <p>far.</p> <p>There are policies and procedures which guide staff in the use of advocacy and support persons. Staff were aware of how to access the Advocacy Service and examples of their involvement were discussed at staff interviews.</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. The facility supports the philosophy of 'Quality of Life', caring and living life to the highest level of independence and happiness</p> <p>Residents interviewed described how they were supported to maintain their independence in many ways, for example, if residents can access the community safely they are encouraged to do so to attend book club, local library, and other rest home activities. If the resident is less mobile family/whanau, staff, diversional therapist or volunteers will take the resident in a wheel chair or facility van to any outings they have identified as important to them.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families/whanau and friends. Family/whanau members interviewed stated they felt welcome when they visited, offered refreshments and were comfortable in their communications with staff. Any changes suggested by family members to improve outcomes for the resident were warmly received by staff and changes implemented accordingly.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that six complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action</p> |

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| | | <p>plans show any required follow up and improvements have been made where possible. The clinical nurse manager (CNM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p> | <p>FA</p> | <p>The new owners understand the principles of consumer rights during service delivery and that consumers must be informed of their rights and the Nationwide Health and Disability Advocacy service. Information on the Code, informed consent, advance directives, resuscitation, the resident welcome pack, input into care planning, complaints/concerns, advocacy and accessing an advocate are provided and staff ensure residents understand the process. Policies and procedures are in place to inform the process.</p> <p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service) through the Clinical Nurse Manager as part of the admission process, information provided to resident and family/whanau, and discussion with staff.</p> <p>The Code is displayed in English and Maori at the front entrance of the rest home and hospital together with brochures and information on the advocacy service, how to make a complaint and feedback forms. Every resident's room has a copy of the Code.</p> <p>Services are provided in a manner that respects consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs as verified in family/whanau interviews.</p> <p>There is an information, communication and language policy that requires all staff to ensure residents and their families have access to comprehensive information about their facility planning and the care they receive. English is to be spoken in front of residents and families unless staff can speak the residents' own first language</p> <p>Training on The Code and advocacy services is provided each year for all staff and was verified as occurring for staff on the April 2018 training day.</p> |

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| <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/whanau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>The service ensures that the resident's rights to privacy and dignity is recognised and respected at all times. Staff understood the need to maintain privacy and were observed doing so throughout the audit while attending to personal cares, knocking on residents' doors prior to entering rooms, ensuring doors were closed while cares were being given, exchanging verbal information privately with residents and their family/whanau.</p> <p>All residents have a private room, some with ensuites, and some with shared bathrooms.</p> <p>Residents are encouraged to maintain their independence. Staff ensure individual care plans are followed, residents are encouraged to attend community activities, participate in clubs of their choosing, and have family gatherings for birthdays and anniversaries in a private lounge on site. Family/whanau are encouraged to have meals with their family member and can attend activities and residents' meetings to give feedback as confirmed in interviews with family members.</p> <p>Individual care plans included documentation related to the resident's abilities, and strategies to maximise independence. 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. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</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 in staff and training records as occurring on the April 2018 training day.</p> <p>Interviews with residents and family/whanau confirmed they had not witnessed any abuse or neglect while in the facility.</p> |

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| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>There is a current Maori health plan developed with input from cultural advisers, the philosophy being Mai Te Timatatanga Ki Te Mutunga Kia Kotahia i Tatou. Inclusive were protocols of when Maori death occurs, Papatuanuku, Maori family health, Maori Culture, Culturally safe practice- Nursing, Practical application, Nursing Care, Guidelines for planning care, Death, dying and Grief, Translations, Common Maori Greetings and responses, History of Hakatere, Te Tiriti o Waitangi, DHB Maori Action Plan 2016/2017 (due to be updated) and Relevant Maori Health Resources.</p> <p>Policies and procedures reviewed included multi-cultural awareness, cultural safety policy which included recognition of Maori values and beliefs, maintaining links with whanau and community and death of a Maori resident. Maori Health Guidelines and a policy on the Treaty of Waitangi were also sighted.</p> <p>Current access to resources includes the contact details of local cultural advisers, the District Health Board Maori health providers, kaumatua and kuia at the local marae Hakatere, Public Health Maori and kaumatua service. Guidance on tikanga best practice is available and is also supported by staff who identify as Maori, whanau members and kaumatua.</p> <p>Staff could describe how they would support residents in the facility who identify as Maori to integrate their cultural values, beliefs and cultural practices and how the principles of the Treaty of Waitangi are incorporated into day to day practice. They were aware of the importance of facilitation and involvement of whanau and others for Maori residents. Staff receive education and training in Maori values, beliefs, cultural practices and awareness of organisational policy and procedures with respect to Maori Health. There were no residents in the facility who identified as Maori at the time of the audit.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p> | <p>FA</p> | <p>There is a cultural safety policy which states all services will be delivered in a culturally safe manner to all residents, family/whanau and that staff will acknowledge each individual's spiritual, cultural values, beliefs and</p> |

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| <p>respect their ethnic, cultural, spiritual values, and beliefs.</p> | | <p>needs. Staff receive training at orientation and yearly as sighted at the recent training day - April 2018.</p> <p>Each residents' culture, values and beliefs were identified on admission and their preferences documented in their care plan. Each resident's personal preferences, required interventions and special needs were included in all care plans reviewed. Residents had dietary preferences, physical, psychological and spiritual preferences documented.</p> <p>Interviews with staff confirmed how staff ensure the residents' needs are met. The clinical leader described systems in place to respect residents' choices whilst also being aware of their safety needs. One example of a resident who likes to go out with family members and come back late, has her care organised around this.</p> <p>Residents and their family/whanau confirmed that they were consulted on their individual culture, values and beliefs and that staff respected these and their individual needs are met. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this demonstrated that individual needs were being met. Two family members confirmed how individual preferences, such as following cricket, tennis, rugby and attendance at church are supported.</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/whanau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe in their environment. The general practitioners interviewed also expressed satisfaction with the standard of services provided to residents and had no knowledge of any exploitation of residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of the required completed training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records.</p> <p>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</p> |

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| | | suspect this was occurring. |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, the diabetes nurse specialist, physiotherapist, occupational therapist, wound care nurse specialist, community dieticians, a psycho-geriatrician and mental health services for older persons. Registered nurses are rostered on every shift and were observed promoting, advising and encouraging best practice with the caregivers on duty. There is regular in-service training for staff and external programmes available. The general practitioners review medically stable residents every three months and more frequently as required. The general practitioners interviewed confirmed the service sought prompt, timely and appropriate medical intervention when required, staff were responsive to medical requests, treatment plans and any changes in medication management.</p> <p>Staff reported they receive management support for internal education through Careerforce training, and there was evidence of staff attending in house training. Staff are also booked to attend external education to support contemporary good practice, for example, infection control, wound care and palliative care.</p> <p>Other examples of good practice observed during the audit included prompt answering of call bells, knocking on residents' doors prior to entering, infection control prevention strategies, such as sanitising of hands and pressure injury prevention strategies. Residents and family/whanau interviewed confirmed their family member needs are promptly and consistently met and care is of a high standard.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Evidence:</p> <p>Residents and family/whanau members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Family/whanau members stated they are invited to attend the three monthly general practitioner review and if</p> |

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| | | <p>unable they are informed of any changes made. The residents can continue with their own local general practitioner while in the facility which benefits the resident by continuity of medical care with a practitioner they are familiar with. This was supported in residents' records reviewed with evidence of resident/family/whanau/GP input into the care planning process.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Recent education was verified as occurring at the staff in-service training April 2018.</p> <p>The clinical leader informed that should a resident require an interpreter, staff would be used to assist initially or family/whanau members, otherwise services can be accessed via the District Health Board or Older Persons Health when required. Staff knew how to access these services and where the information is situated, although reported this was rarely required due to all residents able to speak English. Staff confirmed they are able to provide interpretation as and when needed and the use of family members, and access to communication cards are also available for any potential residents for whom English is not their first language.</p> <p>Residents are assisted with communication aids, such as hearing and visual aids when required. The rest home can request the service that is required, for example, the hearing aid service and some visually impaired residents were observed with big word books and talking books.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. A sample of monthly reports to the owners showed adequate information to monitor performance is reported including financial performance, emerging risks and issues, staffing and occupancy.</p> <p>The service is managed by a CNM who holds relevant qualifications and has been in the role for less than a year. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CNM confirms knowledge of the sector,</p> |

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| | | <p>regulatory and reporting requirements and maintains currency through local and national sector meetings and professional development.</p> <p>The service holds contracts with DHB, MoH and ACC for younger persons with a disability (YPD), respite, complex medical conditions, palliative care. Fifty residents were receiving services under the DHB residential care, including one respite care resident. Three residents (one hospital and two rest home) were under the YPD contract at the time of audit.</p> <p>New Provider Interview:</p> <p>The new provider is Heritage Lifecare Ltd (HLL) which is an established New Zealand aged care provider, currently operating more than 1100 beds in the sector. An organisational structure document sighted details the reporting lines to the board currently in place.</p> <p>It is expected that the senior team and existing staff will remain in place at each facility.</p> <p>The prospective purchaser has notified the relevant District Health Board prior to the provisional audits being undertaken.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | <p>FA</p> | <p>When the CNM is absent, the clinical leader carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a registered nurse (RN) who is experienced in the sector and able to take over.</p> <p>New Provider Interview: The prospective provider has no plans to make any significant staff changes during the transition period. Existing cover arrangements for the day to day operations will remain in place, with access to regional operations managers. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p> | <p>FA</p> | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management</p> |

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| <p>maintained quality and risk management system that reflects continuous quality improvement principles.</p> | | <p>of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and wounds. The organisation uses an external electronic system to document and analyse risk data.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, reporting processes and feedback. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed residents preference for jugs for cream and sauces on tables at meal times. As a result, small sauce and cream jugs on tables have been introduced and were observed on the days of audit in place.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The electronic document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The CNM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The CNM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>New Provider Interview:</p> <p>During the transition phase, HLL policies and procedures will be introduced, including their electronic quality and risk management system.</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 were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owners, quality meetings and staff at meetings.</p> |

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| | | <p>The CNM described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of a significant event made to the Ministry of Health since the previous audit. One police investigation and three coroner's inquests have also been reported. None have been confirmed as completed.</p> <p>New Provider Interview:</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The national quality manager interviewed could verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.</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. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and ongoing annually. Three appraisals are overdue (last completed in 2016), but a corrective action plan is in place to address these.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A contractor is the assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> |

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| <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 (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p> <p>New Provider Interview:</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 could confirm understanding of the required skill mix to ensure rest home and hospital care residents needs are met. The organisation already provides the range of levels of care offered (geriatric/medical, and rest home services) and recognises the competencies and contractual obligations to be met when delivering these services.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately 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, and health information was fully completed in the residents' files sampled for review.</p> <p>Clinical notes are integrated with the general practitioner 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. 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> |

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| <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>Entry criteria is clearly described in brochures and promotional material about the services provided. Residents enter the service when their required level of care has been assessed and confirmed by the local needs assessment and service coordination (NASC) Service. Prospective residents and/or their families/whanau are encouraged to visit the facility prior to admission and meet with the clinical nurse manager. They are also provided with written information about the service and the admission process. The organisation seeks updated information from the person involved, family/whanau members, NASC and the general practitioners for residents accessing respite care.</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. Records 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 District Health Boards '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/whanau.</p> <p>At the time of transition between services, appropriate information, including medication records, twenty-four hours of medication, twenty-four hours of progress notes, short term care plans, wound charts (where applicable), and advance directives are provided for the ongoing management of the resident. A checklist ensures this occurs. All referrals are documented in the progress notes.</p> <p>An example reviewed of a patient recently transferred to the local acute care facility, showed a planned, co-ordinated transfer to the acute care service and transition back again. Family members of the resident were kept well informed during the transfers of their relative as evidenced in documentation in the family notes.</p> |

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| <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 aged residential care.</p> <p>A safe system for medicine management using a robotic system was observed on the day of audit with the staff member wearing an apron signalling medication round in progress, do not disturb. Staff demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage, and the list of medicine competent staff was current.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. A 'Medimap' electronic prescribing system has been implemented and the staff and general practitioners interviewed describe the system as robust and very user friendly. Clinical pharmacist input is provided three monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and were checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. The records of temperatures for the medicine fridge are recorded daily and were within the recommended range.</p> <p>There were currently no residents self-administering medications in the facility, however there are processes in place to ensure this would occur safely.</p> <p>If a medication error occurs the clinical nurse manager and clinical leader are informed, and the incident is recorded on an 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>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> | <p>FA</p> | <p>The food service is provided on site by the kitchen manager and kitchen</p> |

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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>team and 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 March 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 food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed as sighted. The kitchen manager is notified of any allergies, dietary changes, weight loss or other dietary requirements. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available and observed in use. There were enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents and staff were observed assisting residents. Residents were observed to be given sufficient time to eat their meal. Family/whanau members were also observed assisting their family member.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews, satisfaction surveys and residents' meetings minutes.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | <p>FA</p> | <p>Entry criteria is clearly detailed in the relevant material and the clinical nurse manager noted that local residents and local health services are familiar with the services provided by Coldstream Rest Home and Hospital. She also noted that all prospective residents are required to have an updated NASC assessment that assesses them as requiring rest home or hospital level of care. Currently there is no waiting list.</p> <p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC service is advised to</p> |

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| | | <p>ensure the prospective resident and family/whanau are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC service is made and a new placement found, in consultation with the resident, family/whanau and general practitioners. Examples of this occurring were discussed with the clinical nurse manager. 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>The primary assessment process is the interRAI and all residents reviewed had a current one on record. InterRAI assessment reports are comprehensive and detailed. Information is documented using validated nursing assessment tools, such as pressure risk-Braden scale, skin assessment, pain scale, cultural assessment, nutritional screening, falls prevention risk assessment, continence assessment, which contribute to the interRAI assessment.</p> <p>InterRAI reassessments are being completed six monthly and clearly identify any changes in the resident. The sample of care plans reviewed had an integrated range of resident related information. Links between the interRAI outcomes and the goals and interventions in the resident's care plans are not always occurring after the interRAI assessment (see criterion 1.3.8.2)</p> <p>All residents' files reviewed during the audit had a current interRAI assessment. Residents/family/whanau confirmed they were involved in the assessment process.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Consumer service delivery plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidenced service integration with progress notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff.</p> <p>Residents and families/whanau reported participation in the development</p> |

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| | | <p>and ongoing evaluation of care plans.</p> <p>The guidelines for writing documents states that residents will have a care plan developed within 24 hours of admission (see standard 1.3.4 for assessment tools) and an individual lifestyle plan is developed within three weeks of admission. This was evidenced as occurring in records reviewed.</p> <p>Short term care plans are developed in response to specific problems and kept on the resident's record for as long as needed. If the problem continues, it is included in the long-term care plan. The guideline documents include frequency of reviews (See standard 1.3.8).</p> <p>Clinical staff have annual training in care planning.</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.</p> <p>The general practitioners interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard at Coldstream Rest Home and Hospital and the facility has a good reputation in the community. Care staff confirmed that care was provided as outlined in the resident's service delivery plans. A range of equipment and resources were available suited to the levels of care provided and in accordance with the residents' needs.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The activities programme is co-ordinated by a trained diversional therapist, employed four months ago (currently on leave), who oversees the activities assistant. Between them they provide a service to the residents five days a week. The activity assistant interviewed has been in her role for ten years.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments which include the resident and their family/whanau members are regularly reviewed to help formulate an activities</p> |

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| | <p>programme that meets the individual needs and interests of the resident. The resident's activity needs are evaluated as their needs change, monthly, and as part of the formal six-monthly care plan review. An activity survey is completed yearly.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities, exercise classes and regular events are offered. The list of residents' activities were comprehensive and varied, with residents' names recorded on a sheet and ticked off when attending the different activities, as sighted. The list included musicians playing classical music, country and western, war era music, singing and dancing, planned outings, individual outings, volunteers coming to read to residents, and children's groups coming to visit. One on one activities are organised for those who choose not to join the group activities or have special needs. Volunteers take residents out on wheel chair outings, walks, organise and take house, one on one board games, book readings and individual outings, such as personal shopping are frequently occurring.</p> <p>Other activities sighted included weekly indoor bowls, nail art, hand massage, make up and pampering, trips to the library, trips to other rest homes, picnics, reminiscing story times, pets visiting, and gardening. There is a facility van which accommodates nine residents which has wheel chair access to accommodate two wheelchairs.</p> <p>There are inter rest home activities to encourage socialisation, such as the recent yearly inter rest home quiz at a nearby rest home, the monthly inter rest home score bowls and a shield is awarded to the winning rest home, fortnightly ladder golf and fortnightly quizzes. Senior citizens gatherings occur every second month.</p> <p>The physiotherapist and physio assistant under take a mobility/exercise programme with groups and individually (including wheel chair residents) on a daily basis as observed at audit. The distance around either the inside of the building or for those able to walk a circuit outside the facility are added up for the year and a certificate is awarded as the distance frequently equates to a half marathon. The certificate is titled "Keenagers half marathon". Residents interviewed who had achieved the certificate were very proud of their achievements and stated it gave them a goal and</p> |
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| | | <p>improved their physical and emotional wellbeing.</p> <p>The activities programme is discussed at the residents' meeting, residents and family/whanau are invited to these meetings and their input is sought and responded to. Resident/family interviews confirmed this is occurring. Resident minutes and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered and the programme encourages each resident to reach their highest level of independence within the limitations they have.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>PA Moderate</p> | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse.</p> <p>Formal care plan reviews and evaluations are the responsibility of the designated registered nurses. These are not consistently occurring every six months in conjunction with the six monthly interRAI reassessment. There were some examples of changes to the care plan when residents' needs changed; however, the degree of achievement with the goal/s or response to the interventions were inconsistently reviewed after the six-monthly interRAI reassessment.</p> <p>Examples of short term care plans being reviewed were sighted for urinary tracts infections, chest infections, falls and/or any changes in the resident's normal status and progress evaluated as clinically indicated at least weekly and according to the degree of risk noted during the assessment process. Examples of ongoing issues transferred from short term care plans into the long term care plan were sighted. Other plans, such as wound management plans were evaluated each time the dressing was changed.</p> <p>Residents and family/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>Three monthly medical reviews by the general practitioners were consistently occurring.</p> |

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| <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. All residents have the choice of their own general practitioner. If the need for other non-urgent services are indicated or requested, the general practitioner or clinical nurse manager send a referral to seek specialist input. Copies of referrals were sighted in residents' records, including to the physiotherapist, NASC, gerontology clinical nurse specialist, wound care specialist, geriatric medical physician and older persons' mental health service. Referrals are followed up on a regular basis by the registered nurses or the general practitioners. 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>A NASC assessor and general practitioner liaison nurse visited the facility during the audit and when interviewed described the links their teams have with the staff and residents at Coldstream Rest Home and Hospital. Both described timely referrals and treatment of residents by the clinical nurse manager, clinical leader and registered nurses with excellent care provided by the staff and that the service has a good reputation in the community.</p> <p>The facility employs a physiotherapist for six hours per week which improves mobility and maintains fitness for the residents. The physiotherapist described the ongoing benefits of regular access to the residents rather than a one-off referral, enabling individual programmes and re-evaluations of their effectiveness. The physiotherapist has trained a physiotherapy aid to follow up and maintain the exercise programmes in between the days she is not working at the facility.</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> | <p>FA</p> | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required Chemical Handling Approved Handler Training (HSNO). An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are</p> |

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| | | <p>stored and staff interviewed knew what to do should any chemical spill occur.</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> | PA Low | <p>A current building warrant of fitness (expiry date 01 May 2019) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. However, there were some kitchen appliances that did not have the service stickers identified. The environment was hazard free, residents were safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>New Provider Interview:</p> <p>HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of this facility. There are presently no plans for any environmental changes in the facility.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes ensembles and communal areas. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> |

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| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | <p>FA</p> | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | <p>FA</p> | <p>There are several communal areas available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access separate areas for privacy, if 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> | <p>FA</p> | <p>Laundry is undertaken onsite for small items and personal laundry and off site for bed linen and towels by a contracted provider. Care and laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff have undertaken appropriate training including for handling and use of chemicals. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and the external contractors audit activities.</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> | <p>FA</p> | <p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in October 2013. A trial evacuation takes place six-</p> |

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| | | <p>monthly with a copy sent to the New Zealand Fire Service, the most recent being on 22 November 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 58 of residents. A large water storage tank is located at the facility, and there is a generator available for rent if required. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden. Heating is provided by central heating in residents' rooms and under floor heating and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The service provides an 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 quality co-ordinator/IPC co-ordinator. The infection control programme and manual are reviewed annually.</p> <p>An enrolled nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical nurse</p> |

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| | | <p>manager, and tabled at the monthly quality/risk committee meeting. This committee includes the owner/business manager, clinical nurse manager, clinical leader, quality/IPC coordinator, health and safety officer, registered nurses, carers, kitchen manager and maintenance officer.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</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 IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role since 2012. She has undertaken IPC training and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control nurse specialist, Older Persons Health, are available and expert advice from the District Health Board and the laboratory is available if additional support/information is required. The IPC coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There has been a recent outbreak of norovirus (March 2018) in the facility which was well managed. The 'outbreak kit' contains all of the appropriate isolation requirements.</p> <p>Infection prevention and control is part of staff orientation and regular updates and feedback occur with staff as evidenced in staff meeting minutes from the recent outbreak. Hand washing facilities are available throughout the facility and alcohol hand sanitiser is freely available and observed being used by all staff on both days of the audit process.</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</p> | FA | <p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are reviewed yearly and include appropriate referencing.</p> |

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| <p>relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | | <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p> |
| <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 infection prevention and control at orientation and ongoing education sessions. Education is provided by the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</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, increasing fluids to prevent urinary tract infections and extra fluids in hot weather. Families/whanau confirmed they are also given education by staff regarding hand hygiene and staying away if feeling unwell as in the recent March norovirus outbreak. There is a notice at the front entrance giving guidance on this.</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>New infections are reported on the infection control report form and any required short term management plan is implemented and discussed at handover, to ensure early intervention occurs. Entry on to the infections log occurs which develops the short term care plan with interventions, re-evaluations and resolutions. These are closed off when resolved and a copy of the print out sheet goes into the resident's record.</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 individual infection register in the resident's clinical record, infection</p> |

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| | | <p>reporting form, and resident management system. The infection control coordinator reviews all reported infections.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers and improvements identified, such as, in the recent norovirus outbreak. Graphs are produced that identify changes in infection rates in the facility.</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, two residents were using restraints and six residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</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, files reviewed, and from interview with staff.</p> <p>New Provider Interview January 2018:</p> <p>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</p> | FA | <p>The restraint approval group, made up of the CNM and the clinical lead, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting</p> |

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| <p>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> | | <p>minutes, residents' files and interviews 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/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</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 RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/EPOA. The RN/clinical leader interviewed described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p> |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | <p>FA</p> | <p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example the use of sensor mats and low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>An electronic 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. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p> |

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| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p> | <p>FA</p> | <p>Review of residents' files showed that 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. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers 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> | <p>FA</p> | <p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality and staff meetings. Minutes of meeting reviewed confirmed this includes 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 in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated.</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) |
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| <p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p> | PA Moderate | InterRAI assessments are being completed every six months or more frequently as required, however not all care plans are being re-evaluated and updated after the interRAI reassessment process. Documentation in the care plans of the level at which personal goals, response to interventions, the degree of achievement and desired outcomes were not consistently being re-evaluated as required in the standard. | Residents' care plan reviews and evaluations were not consistently being re-evaluated and documented in the care plans after the six monthly interRAI assessments are completed. | <p>Ensure that each resident's care plan is evaluated, reviewed and amended, such process to be informed by interRAI at least every six months as required in the standard.</p> <p>90 days</p> |
| <p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p> | PA Low | Testing and tagging of electrical equipment and biomedical equipment occurs annually. Records sighted showed that this includes all electrical equipment, and a tag is placed on the equipment cord or machine. In the kitchen four items did not have an electrical tag or evidence of a service review. Two items were due in | Four items in the kitchen did not have any evidence of electrical tagging or a service review: the Westinghouse oven; The 'combi' oven; the 'Starline' washer; and the 'deep fryer'. | <p>All equipment is serviced and electrically tested and tagged to comply with legislation.</p> <p>60 days</p> |

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| | | February 2018 and another two did not have any sticker or tag on to state when these were last tagged or serviced. | | |
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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.