

# Heritage Lifecare Limited - Raeburn Lifecare

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## 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:

<b>Legal entity:</b>	Heritage Lifecare Limited
<b>Premises audited:</b>	Raeburn Lifecare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 1 August 2018 End date: 2 August 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	36

# Executive summary of the audit

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## 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
	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
	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
	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

Raeburn Lifecare provides rest home, dementia and hospital level care for up to 54 residents. The service is operated by Oceania and managed by a business and care manager and a newly appointed clinical manager. Residents and families spoke positively about the care provided.

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

This audit has resulted in areas requiring improvements relating to archived records management, documented assessments, monitoring of challenging behaviours, evaluation of care, medication administration including self-administration, restraint use consent and documentation.

This facility is one of several being purchased at this time by Heritage Lifecare Limited (HLL) following the purchases of 16 other facilities since late 2017. HLL is a national provider with senior staff experienced in rest home, hospital and dementia level services. The HLL National Manager Clinical and Quality reported in June 2018 that HLL have a senior project team managing the transition of each new facility to HLL processes over a period of six months. The Raeburn management have been informed of the purchase date and the transition plans by HLL management. The transition will include the changeover to HLL; infrastructure support,

policies, procedures and processes, and information technology systems. Workshops will be held for Raeburn staff as part of the transition plan.

## Consumer rights

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

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

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

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

The requirements of the Code are met including complaints management.

## Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The scope, direction, goals, values and mission statement of the organisation are well known and followed. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded with use of internal and external areas on site used for storage.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

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

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

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

## Safe and appropriate environment

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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Raeburn Lifecare meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. The bulk of the laundry is undertaken offsite at another Oceania facility 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. Families and residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		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 has implemented policies and procedures that support the minimisation of restraint. Two enablers and five restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular review is described in policy. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	43	0	3	4	0	0
<b>Criteria</b>	0	93	0	4	4	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. At the time of audit staff in the dementia unit were observed to offer choices and options to the residents in the dementia unit also allowing for the resident to respond.</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 understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented as relevant and were evidenced in all residents' files reviewed, including enacted enduring power of attorney documents for all residents residing in the dementia unit. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical manager interviewed stated that the residents' meetings are facilitated by an external person from the local community.</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>	<p>FA</p>	<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' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints and concerns policy and associated forms meet the requirements of Right 10 of the Code. There is a flowchart associated with the policy to assist staff in understanding the process for complaints management. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The local health and disability advocate is a regular visitor to the facility at the invitation of residents and staff.</p> <p>Training on the complaints policy and open disclosure is provided to all staff annually.</p> <p>The up to date complaints register reviewed showed that five complaints have been received this year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Written and verbal complaints are documented and responded to. Action plans show any required follow up and improvements have been made where possible. The business and care manager (BCM) is responsible for complaints management and follow up, and was well versed in the principles of open disclosure. 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</p> <p>Consumers are informed of their</p>	<p>FA</p>	<p>Residents and their families interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided for residents entering dementia, hospital and rest home levels of care and discussions with staff. The Code is displayed in several main areas throughout the facility together with information on</p>

rights.		<p>advocacy services, how to make a complaint and feedback forms.</p> <p>The prospective provider interviewed is an experienced aged care sector provider. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the requirements of the Code as part of their existing roles.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by partaking in community activities. There are three residents who choose to have their own GP. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. The residents in the dementia unit have access to a secure garden from the main dining/lounge area. The residents in the hospital and rest home area have access to several lounges and outside areas where they can meet with the families and visitors, other than their bedrooms.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The clinical manager interviewed reported that there was currently no resident who affiliated with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is no specific current Māori health plan, however all values and beliefs would be acknowledged with the support of the Te Whare Tapa Wha model and evidenced and integrated into long-term care plans with input from cultural advisers within the local community as required. Guidance on tikanga best practice was available and supported by staff who identify as Māori in the facility.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are</p>

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The facility encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.  Other examples of good practice observed during the audit included knocking on bedroom doors before entering, acknowledgement of family visiting, and general day to day conversations between staff, residents and families.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff know how to access interpreter services, although reported this was rarely required due to all residents at the time of audit able to speak English. Staff are able to provide interpretation as and when needed and include the use of family members as appropriate. There was one resident identified who has a significant sensory impairment and appropriate resources and equipment was observed to support the resident which included the use of a whiteboard to assist with communication.

<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>Oceania's purpose, values, scope, direction and goals are clearly displayed in Raeburn's reception area and reflect a person-centred approach. The monthly report information is collated at the support office and is used to inform decisions made at the operational level and the monthly board reports. Feedback from the board comes to the Raeburn BCM and clinical manager via the clinical quality and the operations managers. The business and care manager (BCM) works to associated operational plans. Verbal updates are provided to the BCM by Raeburn's head of departments weekly. A sample of monthly statistical reports provided to the BCM by the support office showed adequate information to monitor performance is reported including financial performance, quality and clinical performance and emerging risks and issues.</p> <p>Collated benchmarked clinical indicator data is provided to each facility in graph form indicating place on the league tables across facilities in the Oceania group.</p> <p>The service is managed by a business and care manager (BCM) who holds relevant qualifications and has been in the role for one year. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The BCM is supported by a clinical manager who is a recently graduated, well qualified registered nurse. The BCM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through regular education and networking in the sector.</p> <p>The service holds contracts with the local DHB for respite, rest home, dementia and hospital level care. Seventeen residents were receiving rest home services, 13 residents were receiving hospital level care, and six residents were receiving dementia level care under the contract ARRC contract at the time of audit.</p> <p>New Provider Interview July 2018:</p> <p>The new provider is Heritage Lifecare Limited (HLL), an established New Zealand aged care provider, operating more than 2042 beds in the sector. The acquisition of Raeburn is part of the next round of purchases currently underway which will add several more facilities across the country to HLL group. The National Manager Clinical and Quality reported (July 2018) that the same process used towards the end of 2017 for a series of acquisitions will be used for the purchase of the Raeburn facility and others.</p> <p>An organisational structure document sighted details the reporting lines to the board in place as at 30 November 2017.</p> <p>The transition plan which was commenced in late 2017 is led by an experienced and well-qualified project team who are specifically focussing on the integration of the current facilities into the HLL group. This includes provision of infrastructure support such as providing information technology capability including hardware and software. The workshops to introduce documentation, and the new HLL systems and processes have already commenced for newly purchased facilities and are planned for Raeburn</p>

		<p>and the other facilities being purchased at this time. The HLL project team plan to work with the Raeburn management team to ensure a smooth transition within the first three months.</p> <p>It is expected that the senior team will remain in place at each facility and that existing staff will transfer to HHL.</p> <p>HHL has notified the relevant District Health Board prior to this provisional audit being undertaken.</p>
<p><b>Standard 1.2.2: Service Management</b></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 BCM is absent, the clinical manager carries out all the required duties under delegated authority, with the support of the regional clinical quality and the operations managers. During absences of key clinical staff, the clinical management is overseen by the RN on duty or the regional clinical quality manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>New Provider Interview July 2018:</p> <p>The prospective provider is not planning any staffing changes. Existing cover arrangements for the day to day operations will remain in place, with access to the regional operations managers. The prospective 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><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including pressure injuries, infections and restraint use.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the various monthly meetings, such as team meetings, quality meetings, health and safety meetings, the RNs meeting and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, incident investigation, and meeting involvement. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey in February this year showed satisfaction with the facility and medical services and some areas for improvement required with hotel services. Relevant actions have been taken in response to the results. As the response rate was only 29% another survey has been posted recently.</p> <p>Training is provided to all staff annually on the quality and risk management system (eg, incidents,</p>

		<p>accidents, complaints and hazards).</p> <p>Oceania policies cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Raeburn has a system for ensuring staff are provided with updates on centrally produced new and revised controlled documents including policies and procedures. Staff reported they have ready access to policies and procedures as required.</p> <p>The annual audit schedule is managed by the BCM who delegates activity as relevant to staff roles. The sighted schedule was up to date and feedback has been provided to staff on the outcomes and corrective actions required.</p> <p>The BCM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The BCM has attended the Oceania update on the Health and Safety at Work Act (2015).</p> <p>New Provider Interview July 2018:</p> <p>During the transition phase, HLL policies and procedures will be introduced. The National Manager Clinical and Quality anticipates, a new software system will be introduced to incorporate risk management including adverse event reporting, care planning and client management, within six months of the purchase.</p> <p>HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure. Raeburn clinical staff will be included in the new HLL national clinical governance group, the introduction of which is a key HLL strategy for 2018.</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</p>	<p>FA</p>	<p>All serious incidents/accidents are reported to the clinical manager or RN on duty before the end of the shift on which they occur. Staff initially document adverse and near miss events on an accident/incident form and then the information is entered into the Oceania electronic incident management system via the organisation's intranet by the clinical manager. A sample of incidents reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Sentinel events are investigated by the BCM and the clinical manager. Adverse event data is collated, analysed, benchmarked and reported monthly and provided to Raeburn's BCM and clinical</p>

<p>appropriate their family/whānau of choice in an open manner.</p>		<p>manager by the support office.</p> <p>Resident incidents and accidents are monitored and reported on through the clinical and quality meetings and staff accidents at the health and safety meetings.</p> <p>The BCM described essential notification reporting requirements, including for pressure injuries. These notifications are made by the general manager clinical quality. The BCM advised there has been a recent infection outbreak notification in March of this year made to the local DHB and the Ministry of Health.</p> <p>New Provider Interview July 2018:</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner (HLL) is aware of all current health and safety legislative requirements and the need to comply with these. The HLL national manager clinical and quality interviewed was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Oceania 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, practising certificates (APCs), and driving licences where required. An electronic system is used to track each step of the recruitment and employment system which provides alerts to managers involved in the employment process to ensure all relevant actions are taken. The annual practising certificates are tracked through this system to ensure staff are current. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>A comprehensive staff orientation programme includes all necessary components relevant to the role. Staff reported that the orientation process, which included being 'buddied', prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. First aid certificate holders are indicated on rosters and retraining is monitored to ensure currency of certification. The 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. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The Oceania staffing policy followed reflects this standard and the contract requirements. An RN is onsite 24 hours a day, seven days a week. The Oceania electronic tool based on the Indicators for Safe Staffing is used by the BCM in conjunction with the clinical manager to prepare the rosters fortnightly in advance. Unplanned absences are covered by casual staff and staff doing extra shifts and hours are tracked for staff health and safety. The staffing depends on the number and acuity of residents and incorporates at least one staff member with a first aid certificate on each shift.</p> <p>A potential issue was identified on the day of audit with two syringe drivers being available for use with residents, although no RNs on staff trained in their use. The need to ensure RNs are trained as competent to use the pump before a person is admitted to the facility was emphasised.</p> <p>New Provider Interview July 2018:</p> <p>The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the Guidelines for safe staffing level and indicators. The representative for HLL interviewed was able to confirm understanding of the required skill mix to ensure rest home, hospital and dementia care residents' needs are met. The organisation already provides the range of levels of care (hospital - geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>PA Moderate</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are readily retrievable using a cataloguing system; however, the outside archived system was not stored in an easy to access formalised way, secure from other elements. The document destruction bin was not protected from the environment and was accessible to the public.</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>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 (DSL) Service. Residents admitted to the dementia care services have been assessed by a specialist. Prospective residents and/or their families are</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>encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from DSL and/or the GP for residents accessing respite care.</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. Admissions agreements were sighted for residents admitted to the dementia unit and had been signed by the residents enacted enduring power of attorney. Service charges comply 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 DHB's 'yellow envelope' to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed communication between the GP, facility, family and community support services. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policy was 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 medication competent to perform the function they manage, however a medication observation round during the audit did not show safe administration of medication by a competent registered nurse.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the</p>

		<p>recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three- monthly GP review is consistently recorded on the medicine chart. Standing orders are used, are current and comply with guidelines.</p> <p>There was one resident self-administering medications at the time of audit. Not all appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a kitchen manager who is one of three cooks and the kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration has been issued which expires on March 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. A resident satisfaction folder was sighted in the residents' rest home dining lounge to encourage residents and families to give feedback and suggestions about meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local DSL is advised to ensure the prospective resident and family are supported to find</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.		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 DSL is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, and nutritional screening as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have a current interRAI assessment completed by one of four trained interRAI assessors on site one of which includes the clinical manager. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. For residents admitted to the dementia unit behaviour management plans are developed based on triggers and interventions of challenging behaviours, however not all residents had a behaviour management plan (see criterion 1.3.7).  Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned	PA Low	The activities programme is provided by one activities co-ordinator who is supported through regular

<p>Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>contact with a trained diversional therapist holding the national Certificate in Diversional Therapy employed in other facilities for the organisation. The activities co-ordinator overall supports residents Monday to Friday from 8 am to 4.30 pm and more specifically supports residents in the dementia unit from 10 am to 11 am and 1.30 pm to 3.30pm daily.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents; however not all residents had an evaluation to support the resident's challenging behaviours (see criterion 1.3.8.2) or a supporting 24-hour challenging behaviour plan. The resident's activity needs are evaluated monthly and as changes occur and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction survey. Residents interviewed confirmed they find the programme interactive.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes one to one and distraction, reminiscing and the dementia unit kitten (re: pet therapy).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change; however, not all long care plans or challenging behaviours identified for residents had been evaluated. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, wounds and falls. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to speech language</p>

<p>referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>therapist, dietician and a wound nurse specialist. The resident and the family/whānau 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>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances including policies and guidelines. Training is provided to all staff at orientation and annually on the management of waste and hazardous substance.</p> <p>Appropriate signage is displayed where necessary. There are designated cleaners who work with cleaning chemicals. 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 supplied by the external contractor were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment such as aprons, masks and gloves and staff were observed using this. The storing of full oxygen cylinders set further apart from the empty cylinders is suggested to ensure staff do not inadvertently collect an empty cylinder in an emergency.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness which expires in 12 June 2019, is publicly displayed in reception.</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. The environment is hazard free, residents are safe, and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting, including the ability for purposeful walking for dementia service residents as they are able.</p> <p>Staff and 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 July 2018:</p> <p>HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each facility. There are presently no plans for any environmental changes in the facilities.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility, which are shared by residents. This includes stand-alone toilets and shower rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident 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>Raeburn provides adequate personal space to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff, family and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, in the garden on the patios, or in their own rooms if required. Furniture is appropriate to the setting and residents' needs. Family members were observed as being easily accommodated within the communal areas visiting and at mealtimes assisting residents with their meals.</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>There are guidelines for appropriate use of chemicals and cleaning solutions. These include information about how to handle these products and directions to use material data safety sheets from the product provider and use of appropriate protective equipment and clothing.</p> <p>Training is provided to all staff annually on the use of chemicals and to care and laundry staff on laundry protocols/systems.</p> <p>The bulk of the laundry is transported in laundry trollies offsite to another Oceania facility for washing and drying. Washing is returned dried and folded to a dedicated laundry room for sorting and delivery to</p>

		<p>residents. A small amount of woollens, hip protectors and urgently required residents' clothes are washed and dried outside on washing lines on site or, by family members if requested. Care assistants (HCAs) and cleaning staff demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. The Oceania coloured bucket/bag system is used to differentiate between soiled and non-soiled items. Resident and families 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. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through external provider review and staff and resident feedback.</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>Oceania policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Raeburn's training programme includes annual training on security and health and safety and, six monthly training on fire safety and emergency management.</p> <p>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.</p> <p>The current fire evacuation plan was originally approved on 1 November 1989 by the New Zealand Fire Service (NZFS) and a letter from the NZFS confirming this is dated 30 April 2010. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 30 May 2018, with no issues. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures and the special needs of people with dementia in an emergency. The facility has fire sprinklers throughout the complex.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas BBQ were sighted and meet the requirements for the 60 residents. Water storage tanks are located around the complex. Emergency lighting is regularly tested.</p> <p>Call system audits are completed on a regular basis and residents and families reported staff responded to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and night staff maintain security at night. The need to ensure the sprinkler room is kept secure at all times was highlighted on the day of audit.</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 most rest home and hospital rooms have doors that open onto outside garden or small patio areas. Electrical heating is provided in residents' rooms and in the communal areas. The memory loss (dementia) unit has electrical air conditioning. 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 implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the GP, pharmacy and main local hospital as required. The infection control programme and manual are reviewed annually.</p> <p>The registered 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 by the clinical manager to the business care manager and tabled at the quality/risk committee meeting. This committee includes the business care manager, clinical manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Signage if an outbreak is placed at the main entrance to the facility and 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 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 for two years. She has undertaken regular training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies 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 were last reviewed in April of 2018 and</p>

<p>procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<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>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when a gastroenteritis outbreak occurred in March 2018.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</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. Trends are identified from the past year and this is reported by the clinical manager and reported to all staff. The facility has had a total of 12 infections since January 2018. It was noted that there were no infections for the months of January, February, March or April of 2018. There were no residents identified that required frequent antibiotics. Residents' files reviewed did</p>

		<p>highlighted short-term care plans to support those residents on antibiotics. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. In April 2018, 21 residents and 10 staff consented to the flu vaccine and 20 residents consented to the shingles vaccine. Data is benchmarked externally within the organisation. Benchmarking has provided assurance the infection rates in the facility are below average for the sector.</p> <p>A summary report for a recent gastrointestinal outbreak 1 March 2018 – 13 March 2018 with four residents and eight staff effected was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented. The four residents effected were not included in the March monthly surveillance results.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Oceania 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. Policies include having an onsite restraint coordinator (position description for the role sighted), a Raeburn restraint approval group and oversight by the Oceania national restraint approval group.</p> <p>Approved restraints at Raeburn are bed rails with protectors, chair briefs and lap belts. Restraints were being used by residents in the rest home and hospital. If a restraint is used consent is required by the resident's general practitioner and advocate/EPOA/welfare guardian on their behalf. Residents consent to enabler use themselves. The use of restraints and enablers are to be reviewed regularly and at least three monthly for each resident.</p> <p>The approval group meets six monthly to consider the requirements related to restraint monitoring and quality review and the needs of the resident and whether the restraint / enabler is meeting their needs. (Refer criterion 2.2.5.1)</p> <p>Raeburn's clinical manager in her role as restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, five residents were using restraints and two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</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 July 2018:</p> <p>HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation</p>

		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 and dementia services.
<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>Approval for restraint use occurs following consent by the family, assessment by the RN and the clinical assessment / opinion of the GP, (Refer criterion 2.2.2.1) or other allied health professional.</p> <p>The cultural safety policy refers to incorporating resident's culture, values and beliefs into the restraint assessment process.</p> <p>The Raeburn restraint approval group, made up of the restraint coordinator and other registered nurses (RNs), are responsible for the approval of the use of restraints and the restraint processes onsite.</p> <p>It was evident from review of restraint approval group meeting 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/whānau/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>	PA Moderate	<p>Assessments for the use of restraint were documented and three out of five of the residents for whom restraint were being used had included all the requirements of the Standard included in their assessment.</p> <p>The RN undertakes the initial assessment with the health care assistants (HCAs), restraint coordinator's involvement, and input from the resident's family/EPOA. The restraint coordinator described the documented process. Families confirmed their involvement.</p> <p>The Oceania policy requires the resident's general practitioner to be involved in the final decision on the safety of the use of the restraint, however a signature to confirm the general practitioner's involvement and consent with this was lacking in two residents' files.</p> <p>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.</p> <p>Partially documented assessments were sighted in the records of residents who were using a restraint (see RMSP 2.2.5).</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 the RNs, HCAs and family members, such as the use of sensor mats, and low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe, for example overnight two hourly observation of residents with bedrails and during the day ongoing observation of residents with chair briefs. On the day of audit four out of five residents had consistent two hourly monitoring of the restraint use. Records of monitoring when a restraint is in use had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month by the clinical manager and reviewed at each Raeburn restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and enough 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>
<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 within the person-centred care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. A daughter interviewed confirmed her involvement in the evaluation process, her satisfaction with the consultation by staff and 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>The partially documented assessments sighted in the records of three out of five residents who were using a restraint did not compromise resident safety, however they had not been noticed by staff doing the evaluations of these people. Therefore, the evaluations occurred but were of a poor quality. (see RMSP 2.2.5).</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of</p>	<p>PA Moderate</p>	<p>The Raeburn restraint advisory group undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. The national Oceania restraint group does an annual review of restraint use across the organisation benchmarking each facility and works with individual rest homes to minimise restraint use.</p>

<p>their use of restraint.</p>		<p>Regular restraint meetings and monthly statistical reports are provided to Raeburn managers from the support office and individual use of restraint use is reported to the quality improvement, RN 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.</p> <p>Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with staff and the clinical manager in her role as the restraint coordinator confirmed that the use of restraint is used as a last resort.</p> <p>A six-monthly internal audit that is carried out also informs the relevant meetings, however incomplete documentation on some residents' files was not identified in recent restraint use internal audits (see RMSP 2.2.2). This included a lack of designation being recorded by the RN doing the initial assessment for one person, dates not included with at least two signatures of the consent family member, relationship of the EPOA to the resident not being documented</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)
<p>Criterion 1.2.9.7</p> <p>Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.</p>	<p>PA</p> <p>Moderate</p>	<p>At the time of audit, current files were observed as being kept secure and only accessible to authorised people. The outside storage/maintenance shed, was observed to be locked; however, the archived boxes with residents' files were directly placed on top of each other in no formalised order and were surrounded by maintenance equipment and supplies.</p> <p>The confidential secure document destruction 'wheelie bin' was observed to be padlocked; however, was sighted in the garden outside the office and accessible to the public and environmental elements.</p>	<p>Not all consumer information was secured or stored appropriately.</p>	<p>Ensure that all consumer information is easily accessible when required and protected from the risk of damage to documents and secure at all times.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The staff interviewed could recall the proper procedures required when administering and supporting residents with medication. While observing the medication round at the time of audit the registered nurse who has an up to date medication competency was observed to not check the robotic medication on the electronic device before administering to one resident, not observe four residents taking their medication, and was observed to extract slow release medication from its capsule and administer to a resident; this medication was highlighted in the electronic device to be taken whole.</p>	<p>Medication administration processes were not undertaken in accordance with the organisational policy and good practice in relation to checking and administration of medication.</p>	<p>Provide evidence of safe medication management.</p> <p>30 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>One resident had an assessment completed to assess for competency of self-administration of medication. The assessment was signed by the admitting RN and GP at the time of admission in January 2018, however the required subsequent three-monthly reviews have not been completed. The clinical manager interviewed stated that there is no written record to show the resident has taken their medication or that the registered nurse has asked if the resident has taken their medication. The medication is also not stored in a locked box. In discussions with the resident and staff it was evident that the resident was competent in the self-administering and a locked box was provided at the time of audit.</p>	<p>One resident self-administering their medicines did not have an up to date assessment to show competence to do so, nor had their medications stored in a locked box.</p>	<p>Provide evidence that all residents who are self-administering medicines are meeting the facility's policy requirements to do so safely.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision,</p>	<p>PA Low</p>	<p>All residents have individual details and client specific initial care plans and long-term care plans. Residents have an interRAI assessment completed by one of four trained interRAI assessors on site. Staff interviewed</p>	<p>Three residents' long-term care plans and</p>	<p>Ensure that all long-term care plans and interRAI</p>

<p>evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process. However, one resident admitted 10 January 2018 did not have their initial long-term care plan completed until 18 June 2018; one resident admitted 16 May 2018 did not have their initial interRAI completed until the 29 June 2018; one resident admitted 20 March 2018 did not have a completed initial interRAI assessment or long-term care plan until 18 June 2018. One resident admitted on the 18 February 2018 did not have an initial interRAI assessment or long-term care plan completed until 19 June 2018. An email sighted showed evidence of the facility clinical manager on the 12 June 2018 requesting transfer of the interRAI assessment. An email reply from DSL stated that they were unaware that the resident had transferred from another facility and now resided at Raeburn.</p>	<p>three interRAI assessments were not completed with the required timeframes.</p>	<p>assessments are completed within the required timeframes to meet contractual requirements.</p> <p>180 days</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>All residents had an individual challenging behaviour form that identified the behaviour, intervention and outcome. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process and care provided. Sampling of the dementia unit files reviewed was increased to include all six residents currently admitted in the dementia unit. Three residents admitted, one on the 20 March 2018, 18 February 2018, 18 November 2016 did not evidence a 24-hour 'behaviour clock' to support management of challenging behaviours for the resident across the 24-hour period.</p>	<p>Three of six residents' files reviewed in the dementia unit did not have a 24-hour behaviour clock to support challenging behaviour.</p>	<p>Ensure that all residents in the dementia unit have a 24-hour 'challenging behaviour clock' to meet contractual requirements and support management of behaviour.</p> <p>180 days</p>

<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>	<p>PA Low</p>	<p>Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process and care provided. One resident admitted on the 20 March 2018 does not have a current six-monthly evaluation as the resident's interRAI and long-term care plan were not completed until the 16 June 2018. One resident admitted on the 18 February 2018 also does not have an evaluation as the resident's long-term care plan as the clinical manager interviewed stated that the long-term care plan was not completed until the resident's interRAI was transferred to the facility following an email request to DSL on the 12 June 2018 (see criterion 1.3.3.3). The dementia unit files were reviewed for all six residents currently admitted in the dementia unit. Three residents (one admitted on the 20 March 2018, one on the 18 February 2018 and one on 8 November 2016), did not have an overall evaluation of the resident's individual challenging behaviour episodes.</p>	<p>Two of 16 residents' files reviewed did not have an evaluation completed to support the long-term care plan. Three of six files reviewed in the dementia unit did not have an overall review completed evaluating the resident's challenging behaviours identified on the challenging behaviour monitoring forms.</p>	<p>Ensure that all evaluations are completed to meet required timeframes and contractual requirements.</p> <p>180 days</p>
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p>	<p>PA Moderate</p>	<p>Oceania's policies require the general practitioner to indicate consent for individual use of restraint for their patients on the Oceania form provided. Three out of five residents had the required consent indicated by the general practitioners' signatures, however two residents did not. One RN had not indicated their designation on the assessment although the clinical manager recognised the signature.</p>	<p>Two out of five residents for whom restraints were being used did not have their general practitioner's sign off as part of the consent</p>	<p>Provide evidence the doctor concerned has been involved in the decision process to provide restraint and consents to</p>

<p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>			<p>process, and one RN did not indicate their designation, as required to support safe restraint use.</p>	<p>this practice for all residents concerned and the designation of staff involved is included.</p> <p>30 days</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p>	<p>PA Moderate</p>	<p>Three out of five residents for whom restraint was being used did not have the documentation required completed accurately including no designation of the RN, and no GP signature indicating consent to the restraint. These gaps in documentation had not been identified by either the internal audit or the evaluation process.</p>	<p>Monitoring and quality review of restraint use was inadequate for three out of five residents, such that a lack of complete Oceania documentation was not noticed or rectified in a timely manner.</p>	<p>Provide evidence the required restraint use documentation has been completed for all residents for whom restraints are being used.</p> <p>30 days</p>

(h) Whether there are additional education or training needs or changes required to existing education.				
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.