# Heritage Lifecare Limited - Resthaven Lifecare

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Heritage Lifecare Limited

**Premises audited:** Resthaven Lifecare

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 6 August 2018 End date: 7 August 2018

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 37

# Executive summary of the audit

## Introduction

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

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

## General overview of the audit

Resthaven Lifecare provides rest home and dementia level care for up to 49 residents. The service is operated by Oceania and managed by a business and care manager who also provides clinical management for the service. 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 no areas requiring improvement.

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 Resthaven Lifecare 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 Resthaven Lifecare staff as part of the transition plan.

## Consumer rights

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

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

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

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

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

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

A complaints register is maintained with complaints resolved promptly and effectively

## Organisational management

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

The quality and risk management systems include 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 are 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, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained in using integrated electronic and hard copy files.

## Continuum of service delivery

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

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

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

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A van from another facility is available for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery. Staff working in the service have food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. 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. Laundry is undertaken onsite and evaluated for effectiveness.

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

## Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no restraints were in use at the time of audit. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

The infection prevention and control programme, led by an appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the Canterbury District Health Board, and the group’s clinical risk and quality manager. The programme is reviewed annually.

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

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

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Resthaven Rest Home has policies, procedures and processes in place 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 in both areas of the facility were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, outings, invasive procedures and collection of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s file. Staff demonstrated their understanding by being able to explain situations when this may occur.  All files of residents in the secure unit had EPOAs in place. The requirement for these residents to require care in a secure unit had been endorsed by specialist services.  Staff were observed to gain consent for day to day care and adapt to residents’ requests on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents, their families and EPOAs are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff were aware of how to access the Advocacy Service. Updates on the availability of the advocacy service is included in residents’ meetings and yearly staff training. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents 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, local walks and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Residents in the rest home expressed a high level of satisfaction with the facility’s location regarding easy access to the city. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.  The complaints register reviewed showed that seven complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The business care manager (BCM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents, their Enduring Power of Attorneys (EPOAs) and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed on posters in several areas throughout the facility. Brochures on the Code, together with information on advocacy services, how to make a complaint and feedback forms are available in the facility’s front entry foyer.  Monthly resident meeting minutes evidences discussion on the Code at each residents meeting. All residents and their families are offered the opportunity to attend these meetings.  The prospective provider is an experienced aged care sector provider. Existing clinical staff are transitioning to the new provider following the sale. Training records verify they have a good understanding of the requirements of the Code as part of their existing roles. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents, their EPOAs and residents’ families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and staff’s attention to ensuring residents privacy was maintained was observed throughout the audit. Resident information is held securely. Privacy was ensured when exchanging verbal information, in discussion with families and consultation with the general practitioner (GP). All residents have a private room.  Residents are encouraged to maintain their independence by being enabled to continue involvement in past interests, participate in community activities, enjoy regular outings to the local shops, coffee bars, areas of interest and participation in clubs of their choosing. Each care plan sighted included documentation related to the resident’s abilities, and strategies to maximise independence. A recent addition of a small kitchenette in the rest home, enables residents to access tea and coffee at any time of the day and night, as they feel the need. Residents expressed a high level of satisfaction to this being available to them.  A review of eleven residents records (five in the rest home and six in the secure unit) confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training records. Abuse and neglect are addressed in the facility’s House Rules and Code of Conduct. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | The organisation has a Maori Health Plan policy that demonstrates the company’s commitment to ensuring that residents who identify as Maori will have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. The Maori Health plan is guided by the Maori Philosophy of Health embodied in the Maori model of health ‘Te Whare Tapa Wha’. These four cornerstones are included in a person-centred approach.  There are no residents at Resthaven Rest Home at the time of audit who identifies as Maori. Documentation in the care plans reflect a person-centred approach that includes consideration of a Maori model of health when required. Interviews verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is access to advice from the Canterbury District Health Board (CDHB) if additional support is required to support residents who identify as Maori. Cultural safety and Maori Health are included in the yearly staff training programme. Interview with the resident verifies satisfaction with the care being provided at Resthaven Rest Home. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents, EPOAs and family verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. Documentation, observations and interviews verify the individuality afforded to residents in the secure unit, who while attempting to maintain their individuality are suffering from reduced cognitive function. Staff are observed to be enable the residents to have control and be given choices regarding care routines and processes required to meet their needs.  A resident/family/EPOA satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met, and this supported that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents, EPOAs and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A GP also expressed satisfaction with the standard of services provided to many of the residents at Resthaven Rest Home with complex care requirements.  The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a copy of the facility’s House Rules and the organisation’s Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care nurse specialist, physiotherapist, community dieticians, mental health services for older people, the psycho-geriatrician, and education of staff. The 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 accessing ongoing internal and external education opportunities. Training includes an annual training day, monthly training sessions and access to the national training programme on care of the older adult.  Other examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided, evidenced by an ongoing initiative aimed at a reduction in the number of falls by the implementation of an exercise and strengthening programme.  A commitment to reducing episodes of challenging behaviour in the secure unit is demonstrated by the implementation of the “I love music programme”, whereby residents have MP3 players loaded with personalised playlists of music that connects the resident with the music and memories of their youth. Residents are observed singing and dancing to their own music. The environment is noted to be calm, with no evidence of distress. Residents were observed to be happy.  The GP interviewed described the facility as one that promotes a flexible environment that manages the often extremely complex needs of the residents in a collaborative manner. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents, EPOAs and family members stated they were kept well informed about any changes to their own or their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Residents, EPOAs and family members interviewed verified they were well informed about happenings in the facility.  Interpreter services can be accessed via the CDHB if needed. All present residents had no requirements for access to interpreter services. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Oceania’s strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A sample of monthly reports to the board and head office showed adequate information to monitor performance is reported including staffing, occupancy, financial performance, emerging risks, complaints, adverse events and infection rates.  The service is managed by a BCM who holds relevant qualifications and has been in the combined role of BCM and clinical manager (CM) for two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The BCM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through clinical and leadership courses.  The service holds contracts with the district health board (DHB) for respite, rest home and dementia services and with the Ministry of Health (MoH) for Younger Persons with a Disability (YPD) services. Fourteen residents were receiving rest home level care, including one YPD and twenty-three dementia care, including one YPD, at the time of audit. There were no residents under the respite contract.  New Provider Interview July 2018:  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 Resthaven 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 Resthaven facility and others.  An organisational structure document sighted details the reporting lines to the board in place as at 30 November 2017.  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 Resthaven and the other facilities being purchased at this time. The HLL project team plan to work with the Resthaven management team to ensure a smooth transition within the first three months.  It is expected that the senior team will remain in place at each facility and that existing staff will transfer to HHL.  The prospective purchaser has notified the relevant District Health Board prior to the provisional audits being undertaken. |
| Standard 1.2.2: Service Management  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. | FA | When the BCM is absent, another CM/BCM from within the organisation carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the registered nurse (RN) 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.  New Provider Interview July 2018:  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 regional operations managers. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | 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 infections and adverse events.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality improvement and health and safety team meetings. Staff reported their involvement in quality and risk management activities through audit activities and attendance at quality/health and safety meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed an issue about meal sizes, which has been addressed by the service.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The BCM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.  New Provider Interview July 2018:  During the transition phase, HLL policies and procedures will be introduced. A new software system will be introduced to incorporate risk management including adverse event reporting, care planning and client management. This is anticipated to be within six months of the purchase.  HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. These will be personalised for Resthaven Lifecare. The plan includes internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure. A key strategy to introduce a national clinical governance group is planned in the next 12 months. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse and near miss events on an incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the quality improvement and health and safety teams and electronically to head office.  The BCM described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit.  New Provider Interview July 2018:  There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The national quality manager interviewed was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month and then annual period.  Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. A staff member is the internal assessor for the programme. 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. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of four weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.  New Provider Interview July 2018:  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 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. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records of present residents are held securely on site. Records of residents no longer residing at Resthaven Rest Home are held securely off site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter Resthaven Rest Home when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Residents requiring care in the secure unit have this requirement verified by a psycho-geriatrician and have an EPOA in place.  Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the business and care manager (BCM) or the registered nurse (RN). They are also provided with written information about the service and the admission process.  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. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the CDHB’s ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, EPOA and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic system was observed on the day of audit. All medication charts had up to date resident photographs, this addresses a finding at the previous audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  There were no controlled drugs on site at the time of audit, however controlled drugs can be stored securely in accordance with requirements. Controlled drugs when in use are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  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 electronic medicine chart. This addresses a previous finding whereby inconsistency over medication reviews had been evident  There were no residents self-administering medications at the time of audit.  Medication errors are reported to the BCM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.  Standing orders are not used. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by a qualified chef 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 in March 2018. Recommendations made at that time have been implemented.  A food control plan is in place and is due to expire 28-3-2019. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The chef has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals was verified by residents, EPOAs and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.  Residents in the secure unit always have access to food. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the BCM. 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 | On admission, residents of Resthaven Rest Home are initially assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, social, and behaviour assessments and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents’ changing conditions require.  In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident’s condition changes. Interviews, documentation and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.  Evidence is sighted of comprehensive assessments occurring, specifically following residents having a fall, and includes full neurological monitoring if a head injury is likely or the fall is unwitnessed. In addition, a full post falls assessment is undertaken.  All residents have current interRAI assessments completed by the two trained interRAI assessors on site. InterRAI assessments are used to inform the care plan. |
| 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 are reflected in the care plans reviewed.  The care plan included the required interventions to monitor the resident’s medical conditions and potential medication effects, enabling early interventions in detecting a potential problem.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents, EPOAs 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 of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs.  A previous corrective action around behaviour management plans in the secure unit has been addressed. All residents’ files reviewed where episodes of challenging behaviour occurred, had recorded behavioural management plans and 24-hour activity plans. The behaviour management plans included the behaviours the resident exhibited, possible triggers and the strategies to manage the behaviours. The behaviour monitoring chart documented all episodes of challenging behaviour, and enabled a review by the RN and GP regarding the effectiveness of the strategies in place |
| Standard 1.3.7: Planned Activities  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. | FA | The activities programme is provided by a recreation co-ordinator whose programme is overseen by a trained diversional therapist from another facility.  A social assessment and history are undertaken on admission to ascertain knowledge “about me”, the resident. This identifies the resident’s needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated regularly and as part of the formal six-monthly care plan review. There is a twenty-four hour activities plan for every resident in the secure unit.  The facility does not have a van, and is reliant on another facility lending them one which subsequently limits the availability of outings  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included fortnightly van outings, walks out and about, going out for coffee to a local coffee bar, visits to the local preschool or they come to Resthaven Rest Home, church groups weekly, a gentleman’s group - where a group of men go to a local bar for chips and a drink. In addition, there are group or individual activities in the facility. Entertainers visit weekly. Several residents have accessed the “I love music programme” and spend time listening to their MP3 players. Younger residents go to the library, walk into the city or are assisted to attend events of interest.  The activities programme is discussed at the minuted residents’ meetings and indicated residents, EPOA and family input is sought and responded to. Resident, EPOA and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they enjoyed the activities on offer. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for behaviour management strategies, infections, pain, falls, and weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents, EPOAs and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, BCM or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to older persons’ mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident, EPOA and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident with an escort to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.  There is provision and availability of protective clothing and equipment and staff were observed using this. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 01 July 2019) is publicly displayed.  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 was hazard free, residents were safe, and independence is promoted.  External areas are safely maintained and are appropriate to the resident groups and setting. Those in the dementia wing have areas both internal and external that allows for purposeful walking.  Residents and staff 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.  New Provider Interview July 2018:  HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of Resthaven. There are presently no plans for any environmental changes in the facilities. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.  There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.  There is a small designated cleaning team who have received appropriate training, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.  Cleaning and laundry processes are monitored through the internal audit programme, and by the external contractor. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 16th October 2007. The emergency plan considers the needs of people with dementia. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 01 August 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ’s were sighted and meet the requirements for the full number of residents. Water storage tanks are located around the complex, and there is a generator available if required. Emergency lighting is regularly tested.  Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by electric panel heaters in residents’ rooms and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Resthaven Rest Home provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the BCM. The infection control programme is reviewed yearly, and the policies are reviewed two yearly.  The BCM is the designated infection control nurse whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and tabled at the monthly quality meeting and the staff meeting. Infection control statistics are entered in the organisation’s electronic database and benchmarked within the organisation’s other facilities. The organisation’s regional clinical and quality manager is informed of any IPC concern.  Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control nurse (ICN) has appropriate skills, knowledge and qualifications for the role. The ICN has undertaken on line training on infection control and attended the CDHB infection control study day in January 2018. Well-established local networks with the infection control team at the DHB are available and expert advice from the organisation’s clinical risk and quality manager is available if additional support/information is required. The ICN has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICN confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed September 2017 and included appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. Staff are offered the opportunity to receive organisation funded influenza vaccinations if desired. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the BCM. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent outbreak of norovirus in January 2017.  Education with residents or their EPOA 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. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident’s clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  The ICN reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation’s electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group’s other aged care providers.  Evidence verifies the number of infections is low, with the incidence being higher in relation to skin infections. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her role and responsibilities.  On the day of audit, no residents were using restraints and no residents were using enablers.  The last reported restraint in use was over two years ago.  New Provider Interview July 2018:  HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for use of enablers. These policies are implemented across the group and a small number of restraint devices are approved for use following assessment. The prospective provider is experienced in the requirements of the standard, as it pertains to aged residential care and dementia care services. |

# 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.

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| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.