

Heritage Lifecare Limited - Stillwater Gardens 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](#).

The specifics of this audit included:

Legal entity: Heritage Lifecare Limited

Premises audited: Stillwater Gardens Lifecare

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

Dates of audit: Start date: 11 October 2018 End date: 12 October 2018

Proposed changes to current services (if any): This provisional audit was in response to a request due to plans underway for the sale and purchase of Stillwater Gardens.

Total beds occupied across all premises included in the audit on the first day of the audit: 67



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

Stillwater Gardens provides rest home and hospital level care for up to 69 residents. The service is operated by a limited liability company and managed by a general manager and a clinical services manager, with support from a personal assistant. There have been no changes to the service since the previous audit, although sale of the facility is imminent, which prompted a provisional audit. Residents and families are fully satisfied with the care and services 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 observations, review of policies and procedures, review of residents' and staff files and interviews with residents, family, management, staff, (contracted allied health providers), general practitioners and the prospective owners.

This audit has resulted in two areas identified as requiring improvement. One related to the need for Enduring Power of Attorney documentation to be available and activated for residents in the dementia service and the other related to the need for the service delivery plan of a respite care resident in the dementia service to more accurately reflect their needs.

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, informed consent and availability of advocacy services are taken at the time of admission and thereafter as required.

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

Systems are in place to enable residents who identify as Māori to have their needs met in a manner that respects their cultural values and beliefs. Care 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 strong linkages with a range of specialist health care providers, which contribute to ensuring services provided to residents, are of an appropriate standard.

Policies and process are in place to manage the small number of complaints received. These are recorded on a register which shows investigation and resolution occurring.

Organisational management

Stillwater Gardens Rest Home and Hospital has one director/general manager (GM) who provides governance and oversight of the service. There is a business plan in place which guides the organisational strategies. There is a suitably qualified and experienced clinical nurse manager.

A quality and risk plan is in place, with a calendar of audits and includes complaints and adverse event management. Where required corrective actions are undertaken. Risks including health and safety, are documented, with mitigation strategies and reviews. Quality improvement activities are logged. Regular reporting occurs to the GM and to staff at their meetings. Policies and procedures are in place covering all areas of the business and are regularly reviewed.

Recruitment processes meet current good practice, staff are given orientation and have access to a programme of training related to the resident group. Staff undertake annual appraisals and all health professionals have a current annual practising certificate. A documented process on staffing levels related to resident numbers and needs is in place.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Adequate information about the service is available to prospective residents and their families. The service provider works closely with the local Needs Assessment and Service Co-ordination (NASC) Service, to ensure access to the facility is appropriate. Services are being provided by trained caregivers under the supervision of a clinical manager and other registered nurses who are on duty 24 hours each day. Consistent processes around service delivery were evident across all three types of services: dementia, rest home and hospital.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. A range of assessment tools are used for this purpose and interRAI is well entrenched into this service.

Care plans are individualised, based on a comprehensive and integrated range of clinical information, including interRAI outcomes. Short term care plans and wound care plans are developed when required. All residents' files reviewed demonstrate 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. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

A planned activity programme is led by two diversional therapists. This provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures, which meet the requirements of relevant legislation, guidelines and best practice principles. An electronic medicine management system is in place. Medicines are administered by staff who have been assessed as competent.

The seasonal rotating menu has been reviewed by an appropriate professional to confirm food services meet the nutritional needs of the residents. Personal preferences and any special dietary needs are catered for. A food safety plan has been developed. Relevant policies guide food service delivery and food safety. Residents verified satisfaction with the meals.

Safe and appropriate environment

The facility is purpose built and meets the needs of the various resident groups, it is clean and well maintained. There is a current building warrant of fitness. All rooms are single with ensuite bathrooms. A number of communal areas are available to residents, family members and visitors with space for activities to occur. Numerous external areas, including internal courtyards, are used by residents and family members, shade for external areas is available in summer. Equipment is regularly tested and monitoring of the environment occurs and includes temperature to ensure comfort.

Waste and chemical management is documented and staff have access to personal protective equipment. Cleaning and laundry services are undertaken by dedicated staff members who follow documented policies and procedures and have received training on the chemicals they use. The chemical company tests for the effectiveness of the laundry chemicals and processes.

Emergency management plans and security processes are in place, and staff have training related to these areas. Fire drills occur six monthly and staff attendance is recorded. Residents and family members report timely response to call bells.

Restraint minimisation and safe practice

Restraint minimisation is practiced by the organisation, with policies and processes in place for staff to follow. Training on restraint and challenging behaviour management occurs regularly. Restraint is overseen by the clinical nurse manager and a restraint committee. During the audit, three residents had enablers in use and five residents had restraint in use. Documentation of assessment, approval, monitoring and evaluation is in place.

Infection prevention and control

Infection prevention and control is led by the clinical nurse manager. An infection control programme is in place and is reviewed annually. Policies and procedures are in place and staff have a good knowledge of these. Training and auditing of infection control occur regularly. Appropriate aged related surveillance is occurring and regular reports occur to all levels of the organisation

External advice on infection control is available from the local DHB and specialist advisor. No infection outbreaks have been recorded.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	1	1	0	0
Criteria	0	96	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

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

		<p>file. Staff demonstrated their understanding by being able to explain situations when this may occur. Multiple examples of staff gaining consent from residents for day to day care were observed throughout the audit.</p> <p>The general manager and clinical manager informed advance care planning is encouraged; although few examples were available. There was evidence of efforts being made to establish and document enduring power of attorney requirements; however a corrective action has been raised to address the large number of residents in the dementia service who do not have documented evidence on site of an enduring power of attorney (welfare) being available or activated.</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>Residents are provided with a copy of the Code, which also includes information on the Advocacy Service during the admission process. A Stillwater Gardens information booklet that is also provided includes information about the Advocacy service and contact details. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff confirmed they are aware of how to access the Advocacy Service although could not inform of any examples for when this had been required. The clinical manager noted that family members are the most frequently used advocate.</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>There are no set visiting hours and family/ whānau are encouraged to visit and/or take the resident on an outing. Family members interviewed stated they feel welcome when they visit and are comfortable in their dealings with staff.</p> <p>Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/ whānau /resident interviews and documented in daily and planned activities in residents' progress notes and care planning. Examples included visiting the local shopping centre or cafes and community groups regularly visiting the facility.</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>There is a complaints policy, procedure and form which meet the requirements of Right 10 of the Code. Information on the complaints process is provided to residents and families prior to admission and complaint forms are available at reception. Family and residents interviewed knew who they would speak to if they had concerns, but no issue was raised.</p> <p>The electronic complaints register reviewed showed that four complaints have been received year to date, this also stated the actions taken, through to an agreed resolution. The clinical nurse manager who maintains the register was able to provide evidence of action being taken as required following a complaint. Timeframes meet the requirements of legislation. One resident had used the services of the local Health and Disability Advocacy Service to record her concerns. One complaint had been received through the Health and Disability Commissioner's office and had been responded to and was awaiting an outcome by the Commissioner's office. This was the only complaint that remained open.</p> <p>All staff interviewed confirmed they had received training on complaints and an understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) although some were unsure who had informed them. Information about the Code and the advocacy service is included in the information booklet provided on admission to the facility. This includes a copy of the Code plus a copy of a brochure entitled Stillwater Gardens Retirement Village: The Rights and Responsibilities of the Elderly. Copies of the Code are displayed on a stand at the front desk together with information on advocacy services. The diversional therapist informed that she has had times when she has needed to respond to questions about residents' rights and the advocacy service and takes time to remind them about their rights.</p>

		<p>The prospective provider (Heritage Lifecare Limited (HLL)) is an experienced aged care sector provider. The HLL quality and compliance manager stated existing staff will be transitioned to HLL policies and processes. The present staff interview show 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>	<p>FA</p>	<p>Residents and families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understand the need to maintain privacy and were observed doing so throughout the audit whilst attending to personal cares, by ensuring resident information was held securely and privately and during exchanges of verbal information. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by doing as much as they can for themselves. All care plans reviewed included documentation related to the resident's abilities along with strategies to maximise their independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Family members, residents and staff provided examples in which these aspects are being followed through and examples of this occurring were observed during the audit.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records.</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>	<p>FA</p>	<p>A Māori health plan that has been developed with input from cultural advisers is available. This is intended to support the service provider's commitment to meet the needs of residents who identify as Māori, and their whānau. The new provider has solid policies and procedures related to honouring the Treaty of Waitangi, ethnicity awareness and cultural aspects of service provision.</p>

		<p>The clinical manager described how principles of the Treaty of Waitangi are incorporated into day to day practices and stated that staff are very aware of the importance of whānau to Māori residents. Staff informed that Māori staff are always happy to support anyone who enters the facility who identifies with Māori culture.</p> <p>There is currently one resident at Stillwater Gardens who identifies as Māori and although unable to be interviewed during the audit, the care plan includes evidence that whānau are closely involved. Values and beliefs are documented, and communication records and progress notes show these are respected. The care plan notes that the person has chosen not to use a Māori framework for their care plan.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Each resident's personal preferences and their required interventions and special needs were included in all care plans reviewed. These were especially evident in residents' diversional therapy/activity plans. Examples sighted included shopping trips, café visits, church service and communion attendance and followers of various sports. There are three people of other nationalities who have lived in New Zealand for many years. All receive visitors who speak their own language with them. One also goes out with their friend from their homeland. No other specific cultural needs have been identified. A resident satisfaction questionnaire includes evaluation of how well residents' cultural and spiritual needs are met and affirmative responses were noted.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Organisational policies and procedures, as well as the orientation process for new staff, include information related to expected behaviours. Staff are provided with a Code of Conduct and its contents are further described within their employment contract. When interviewed, staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow</p>

		should they suspect this was occurring.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice was observed and evidenced in interviews with the registered nurses and caregivers and through care planning reviews. Policies and procedures and the quality and risk management system are supplied by an external quality consultant with expertise in service delivery for older adults. These documents are referenced and have clear links to evidence-based practice.</p> <p>There are regular visits by residents' GP, physiotherapist, dietician and a podiatrist who provide additional expertise. The facility also has links with the older person's mental health services and a visiting palliative care nurse.</p> <p>Staff reported they receive management support for external education to enable contemporary good practice. A range of initiatives to improve practices have been introduced with examples being promotion of the use of short term care plans and development of a more effective handover process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they are kept well informed. All interviewed confirmed they are updated about any changes in the resident's status and are advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the family/ whānau record in each resident's file that was reviewed. There was also evidence of both resident and family input into the care planning and reviews processes.</p> <p>Staff understood the principles of open disclosure. Policies and procedures on open disclosure meet the requirements of the Code. Evidence of open disclosure occurring was found on completed incident/accident reports.</p> <p>The clinical manager informed that interpreter services can be accessed through the local DHB, but that to her knowledge these have never been required for rest home or hospital residents at Stillwater Gardens. Family members have assisted when needed with admission processes</p>

		<p>for residents with dementia or those who were very unwell and struggled with communication. Staff informed they have acquired and been trained to use different strategies for communicating with residents, or family members, with a range of communication challenges.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The GM provided a copy of the business plan for 2018 till 2020. This outlines the purpose, mission and philosophy of the organisation which has a strong family focus. It contains future objectives and strategies, and describes external professional supports for the organisation, such as Healthcare Compliance Solutions and accountancy. Samples of monthly reports to the GM were sighted and contain sufficient information for decision making.</p> <p>The owner/director/general manager (GM) has been involved in the retirement sector since 1994 and has been in this position for 15 years. They are suitably qualified for the role. The GM stated that her role is more oversight and governance and this has been more so in recent months due to family illness, but she continued to be in regular touch with the clinical nurse manager (CNM) and service personnel assistant. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements. This was confirmed with the review of staff files, which included the job description of the CNM, and interview with staff. The CNM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through attending meetings, such as the DHB update days for residential care contract holders.</p> <p>The service holds contracts with DHB, MoH for Young Person with a Disability (YPD), respite, rest home, hospital and dementia care. At the time of audit there were 67 residents, 15 in dementia unit residents, 24 hospital residents, 25 rest home residents and 1 YPD resident, and two respite care.</p> <p>The prospective owner (Heritage Lifecare Limited (HLL)) is an established New Zealand aged care provider, currently operating more than 2300 beds in the sector. An organisational structure document, details the reporting lines to the board currently in place. The</p>

		<p>prospective owners provides aged related services and have a working knowledge of the contracts the present owner operates under.</p> <p>The HLL clinical quality and compliance manager spoke of planning for the transition and stated that the structure within the facility would remain unchanged, including registered nurse full time equivalents. The transition plan is led by an experienced and well qualified team with weekly meetings with a transition co-ordinator. The Nelson Marlborough DHB and the Ministry are aware of the plan to purchase this service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the GM the CNM and service personal assistant take on appropriate roles. This was confirmed by the CNM who also stated that the GM is always available on her cell phone or computer if there is an issue that needs their input. In the absence of the CNM, the quality coordinator (who is a senior RN) or another senior RN will take on the role. The CNM spoke of how an organised hand over would be undertaken.</p> <p>Staff report they feel supported by management and know who to go to at all times.</p> <p>The HLL quality and compliance manager stated that they will continue with the present management structure and arrangements including contingencies when senior staff are not available.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a senior Registered Nurse (RN) who has two days a week dedicated time to quality and risk management. She was away during the audit and the CNM stood in for the RN during the audit. A current quality assurance and risk management programme is in place, which reflects a continuous quality improvement process. This includes management of incidents, complaints, patient/family satisfaction surveys, restraint minimisation and infection prevention and control. A list of areas of quality improvement are kept; these can arise from the activities of this programme.</p> <p>Weekly RN meeting minutes and monthly management reporting</p>

		<p>reviewed confirmed regular review and analysis of quality indicators. Related information is reported and discussed at the area specific staff meetings and minutes confirmed this. Relevant corrective actions are developed and implemented to address any shortfalls. Resident/family members satisfaction surveys are completed annually, review of these showed issues being brought up by residents and action being taken, such as a food temperature issue, with monitoring occurring to ensure food temperatures were consistent with requirements.</p> <p>The organisation uses an external provider for its policies and procedures and these are all current, reviewed on an annual or two-yearly cycle and meet current good practice. The CNM spoke of how they distribute changed documents and new processes to staff to ensure staff awareness of the changes. Those 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.</p> <p>The CNM provided evidence of the risk management process. Review of the risk/hazard register showed risk/hazard identification, rating, and development of mitigation strategies. The organisation is familiar with the Health and Safety at Work Act (2015) and requirements have been implemented. A Health and Safety Committee has been formed and meet regularly.</p> <p>HLL have a corporate quality and risk management plan which includes an audit schedule, clinical indicators, policies and procedures that meet the requirements of the standard and contract requirements. The quality and compliance manager spoke of a three month transition plan following purchase of the organisation to make the change to the HLL policies and procedures and reporting processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Accident/incident forms are available to staff in each area. Staff interviewed are aware of these and state they use the form to report incidents and near miss events. A sample of incidents reviewed showed compliance to organisational policy, investigation occurring and where required corrective actions being undertaken.</p> <p>Accidents/incidents where harm has occurred are discussed at the</p>

		<p>weekly RN meetings. Information is logged onto the electronic incident management system. This register is used to collect and collate data. Analysis and trending is reported to the GM, RN and meetings such as area staff meetings and health and safety.</p> <p>There is a policy which covers essential notification reporting requirements, including for pressure injuries and these are known to the GM and CNM. There was evidence of this occurring where required. There has been no police investigations or coroner's inquests, issues based audits or notifications such as to public health since the last audit.</p> <p>The prospective new owner understands the legislative and compliance issues of the sector and the different contractual requirements such as the Age Residential Related Care (ARRC) agreement.</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>The CNM provided evidence of how the organisations human resources management policies and processes are followed. These meet current good practice and relevant legislation. Review of three new employee's files confirmed this practice and files contained, interview forms, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The personal assistant provided evidence that all RN's, have current annual practising certificates, they also collect the general practitioner APC information.</p> <p>An orientation process includes checklists to cover key components of employment and care delivery and all necessary components relevant to the role. Staff reported they have completed an orientation process and had a 'buddy' to work with them to prepared them well for their role. A range of staff personnel files reviewed show documentation of completed orientation and an annual performance review occurring.</p> <p>An annual training calendar is in place and includes 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. The staff member who is the internal assessor for the programme provided evidence of staff completion of these requirements. This included care staff working in the dementia care area have either completed or are enrolled in the required education. There are five trained RNs who are</p>

		maintaining their annual competency requirements to undertake interRAI assessments.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The organisation has a clearly documented rationale for staffing levels and skill mix to provide safe service delivery which covers all duties, seven days a week. There is evidence, from the CNM and staff interviewed, that staffing levels are adjusted to meet the changing needs of residents. The CNM is on call after hours, and stated a call is a rare occurrence as there is a RN on duty each shift. Care staff report feeling well supported, and there were adequate staff available to complete the work allocated to them. This was observed during the audit. Family members interviewed supported this. Review of a six-week roster cycle confirmed staff cover has been provided, as per policy. The personal assistant spoke of how she replaces staff for unplanned absence and this was observed. Staff files reviewed showed the majority of staff have a current first aid certificate and at least one staff member is on duty who has a current first aid certificate. This was confirmed by the personal assistant. An RN is on each duty seven days a week, with a second RN on in the mornings to cover the dementia and rest home areas. This was confirmed by RNs and care giver staff. There are separate kitchen, cleaning and laundry staff.</p> <p>The prospective owner stated that there is the expectation that the management team will remain in place with the exception of the GM and existing staff will transfer over. The present roster system would remain in place. HLL has a documented policy based on the guidelines for safe staffing levels and indicators which will eventually be introduced.</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>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information being entered into the Momentum electronic database. Records were legible with the name and designation of the person</p>

		<p>making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with one of the managers. They are also provided with a booklet on Stillwater Gardens and other documentation including forms to be completed, in a package dedicated to the admission process. A waiting list for entry is in place with urgent prospective hospital level care residents given priority. For residents accessing respite care, the organisation seeks updates from health services previously involved in a resident's needs including the NASC team, the GP and/ or the hospital, as applicable.</p> <p>Admission agreements that meet contractual requirements are filed in a secure system in the office. Admission processes are undertaken by a registered nurse who has been allocated for overseeing the initial care plan development for the person. A new resident orientation process is provided for all levels of care. Family members/ whānau are encouraged to accompany the resident for their admission whenever possible.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	FA	Exit, discharge or transfer is managed in a planned and co-ordinated

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>manner, with an escort as appropriate. Family members may be asked to assist when appropriate. The service uses the DHBs 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, latest interRAI results and care plans are provided for the ongoing management of the resident.</p> <p>All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed open communication at both ends of the hospital stay. No example of discharge and transfer to another facility was available. Respite care residents may return using updated records from previous visits.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and describes all aspects of medicine management. The documentation is in line with the requirements of legislation and the Medicines Care Guide for Residential Aged Care. These include competency requirements, prescribing, recording, a process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents</p> <p>Medicines are supplied to the facility in a pre-packaged robotic format from a contracted pharmacy. The medicines are checked by a registered nurse against the prescription. All medications sighted were within current use by dates.</p> <p>Medicines are stored in medicine trolleys in the nurses' stations in the respective areas for dementia, rest home and hospital services. These are locked when not occupied. A locked safe is used for controlled medications and the medicine register was sighted and meets requirements. Six monthly pharmacy reconciliation of the controlled medications register was also evidenced. Clinical pharmacist input is provided monthly. Medications that require refrigeration are stored in a separate fridge. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p>

		<p>A safe system for medicine administration using an electronic system was observed on the day of audit. 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. Documented competencies sighted for the staff responsible for medicine management, which include registered nurses, enrolled nurses and senior caregivers, were sighted. Some only have competencies for checking processes. The electronic system has meant there is no longer a need for either verbal or standing orders.</p> <p>Good prescribing practices were evident within the electronic records reviewed. The clinical manager runs a report every Friday to check that administration records, discontinuation of medicines and all other requirements such as for pro re nata (PRN) medicines are being adhered to. Any omissions or incongruences are followed up. The required three monthly GP reviews of residents' medicines were evident in the records reviewed.</p> <p>There were two residents who were self-administering inhalers or sublingual medicines. Appropriate processes were in place to ensure these are managed in a safe manner.</p> <p>Medication errors are reported to a registered nurse and the clinical manager. All are recorded on a separate medicine error 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 is verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by qualified cooks and a kitchen team. The menu rotates four weekly and has winter and summer variations. It has been reviewed by a dietitian within the past two years to confirm it is in line with recognised nutritional guidelines for older people. Residents' records showed that when unintentional weight loss is recorded, the resident is discussed with the GP and referred for review by a dietitian.</p> <p>A nutritional profile is completed for each resident by the registered nurse upon entry to the facility and this information is shared with the</p>

		<p>kitchen staff. A copy remains in the kitchen. This process ensures food preferences, dislikes and any special dietary requirements of the residents are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day. Special equipment, to meet resident's nutritional needs, is available.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The facility has always operated under a food safety programme and presented the required food safety plan to Ministry of Primary Industries earlier in 2018. An email sighted confirmed this is still being considered by the Ministry. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>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. On the two days of audit, there were sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>According to a manager interviewed, if a referral is received but the prospective resident would not meet the entry criteria or there was no vacancy, the local NASC would be advised to ensure the prospective resident and family members were supported to find an appropriate care alternative. Likewise, if the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC would be made and a new placement found, in consultation with the resident and whānau/family.</p> <p>The manager advised that to date this had not been an issue needing to be addressed, although only the previous day a possible transfer was being further investigated to ensure their suitability. Examples of transfers between various levels of care such as between rest home</p>

		and dementia services into hospital care were provided. There is a clause in the access agreement related to when a resident's placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Assessment processes identify deficits and provide information to inform the care planning process. The sample of service delivery plans reviewed had an integrated range of resident-related information. All residents have a current interRAI assessment on file that has been completed by one of the trained on site interRAI assessors. Information from the interRAI assessment is complemented by that obtained from a range of other assessments for continence, nutrition (plus completion of a dietary profile), falls risk (Coombes), skin integrity (Braden), pain (Abbey), activity (plus a personal profile) and behaviour. Other assessments viewed related to restraint use, cognition and the ongoing monthly (or three monthly when the resident is stable) medical reviews.</p> <p>Residents and family members confirmed their involvement in the assessment process and there was evidence of their signatures in residents' files. Discharge summaries and reports from needs assessors were also available in residents' files. There was clear follow-through of the collective information obtained from the various assessments within the care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment processes including other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in care plans reviewed.</p> <p>With the exception of the care plan identified in the corrective action under 1.3.3.3, all care plans reviewed included goals and an overview of requirements for each that are supplemented with clear descriptions of the person's care and support needs.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Ongoing assessments are occurring and any change in care required is documented and verbally passed on to</p>

		relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision.</p> <p>The GP interviewed described Stillwater Gardens as a very good nursing home and verified that medical input is sought in a timely manner, medical orders are followed, and care is overall excellent. More family members are involved in multi-disciplinary meetings than previously. Registered nurses are generally very knowledgeable and the GP had no cause for concern.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. The new handover system is reportedly working well for them. A visiting palliative care nurse specialist was interviewed and noted that that her advice, education and support to the registered nurses was always well received, that Stillwater Gardens is an excellent facility and provides good care.</p> <p>A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy.</p> <p>In consultation with the resident and family members, a social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. From this information a personal profile is developed and an activity plan developed. Activities assessments both at the individual level and the organisational level are regularly reviewed to help formulate an activities programme that is meaningful to the residents. Each resident has attendance records completed and progress reports written up two to three times and a month and their activity needs are evaluated as part</p>

		<p>of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data and are appropriate for the facility. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include newspaper reading, visiting entertainers, games, walks to local café and celebrations of the seasons and routine events. The activities programme is discussed at the minuted residents' and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents who attend activities confirmed they find the programme fun, full of variety and sociable.</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. There is 24 hour guidance for the occupying the person in each of the resident's files reviewed in the dementia service. One of the diversional therapists is allocated to the dementia service and provides resources to care staff for use in her absence.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse. A written and verbal handover is now undertaken and service providers were all positive about this.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Evaluations are documented by the registered nurse. Where progress is different from expected, the service responds by initiating changes to the plan of care. Risk management is evaluated at the time of service plan reviews. The GP reviews are occurring within the timeframes as noted by the GP at their previous visit, although there were multiple examples of interim visits that have occurred because of a change in a resident's condition.</p>

		<p>Two examples of short term care plans were evident, and one wound care plan. Although one of these was new, there was evidence of ongoing and consistent evaluation and review occurring within appropriate timeframes for the problem identified. Short term plans that had been closed off were also reviewed.</p> <p>Residents and family members/whānau who were interviewed provided examples of their involvement in evaluation of progress and any resulting changes. Evaluation records are signed by all team members, including residents and family members involved.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner and one resident informed that staff have been told of the person's preference to return to a previous GP.</p> <p>If the need for other non-urgent services are indicated or requested, the GP or registered nurse sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older person's mental health, the hospital eye department, neurology clinic, plastics and dental services. Referrals are followed up on a regular basis by the registered nurse or the GP as applicable. Community organisations such as Alzheimer's New Zealand and the Stroke Foundation are also accessed when indicated.</p> <p>The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Waste management policies are in place which covers segregation and safe storage. The maintenance person provided evidence of the external storage of waste, this includes recycling, all waste is removed by an external contractor. Chemical storage is safe and observed in care areas, cleaner's trolleys, kitchen and laundry. Material safety data sheets are in all areas where chemicals are stored. Hazchem signage</p>

		<p>is displayed outside the external gas bottled storage. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. This was confirmed by staff spoken with.</p> <p>There is provision and availability of protective clothing and equipment and staff were able to state when they would use these and were observed using them.</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 (expiry date July 2019) is displayed in the entrance to the facility.</p> <p>The facility was purpose built and the environment is fit for the resident groups they care for and were seen as being well maintained. The maintenance person has an audit schedule which monitors the residents' physical environment. The CNM maintains a record of the annual and biennial testing of equipment. Review of the records identified testing and tagging of electrical equipment and calibration of biomedical equipment. A sample of equipment showed currency of testing. The corridors have hand rails and equipment is being stored out of main thoroughfares to ensure a hazard free environment. It was observed that residents are safely moving around the environment with and without aids and assistance of staff and independence is promoted.</p> <p>There are a range of external areas, including internal gardens. These are safely maintained and are appropriate to the resident groups and setting.</p> <p>Staff are able to state how they report repairs or maintenance issues and records of these were sighted. Staff stated these are followed up in a timely manner. Residents and family members spoken with are happy with the environment.</p> <p>The prospective owners are undertaking a period of due diligence, including building reports, in preparation for the purchase of the facility. There are presently no plans for any environmental changes in the facility.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All rooms are single with ensuite bathrooms. Additional toilets, showers and spa bath are available. Safety handrails are provided in the toilet/shower areas, and equipment, such as hoists are available.</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>All rooms are single and spacious, with adequate space to allow residents and staff to move around within the bedrooms safely. It was observed that residents had personalised their rooms with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs including electric wheel chairs. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are lounge and dining rooms in each of the three areas of the facility, plus additional areas such as reception. Communal areas are available for residents to engage in activities. These areas are spacious and enable easy access for residents with and without aids and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is undertaken on site in a dedicated laundry. There are separate clean and dirty areas of the laundry with documented processes for the different types of washes. Staff are employed for this area and when spoken with and observed demonstrated a sound knowledge of the laundry processes, including dirty/clean flow and handling of soiled linen. Residents personal laundry is also done onsite. Residents and family members 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, including infection control and chemical use. Chemicals were stored in lockable areas and were in appropriately labelled containers.</p> <p>Records of the laundry processes being monitored by the chemical</p>

		company provider were sighted. Cleaning processes are monitored through the internal audit programme.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Emergency and disaster management policies, procedures and guidelines to follow should these events occur are in place, displayed and known to staff. The New Zealand Fire and Emergency Service approved the evacuation plan in May 2012 and there has been no changes to the building since then. Six monthly trial evacuations take place, with a copy sent to the New Zealand Fire Service. This is done on an area by area basis with the hospital and dementia area being carried out in June and the south of the hospital in December. This was confirmed by the CNM and staff interviewed. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>The organisation has stores of supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, gas BBQ's, and incontinence products are in place to meet the requirements for the 69 residents. The personal assistant provided evidence of the regular checking of these stores. The maintenance person stated water storage is located in the ceiling space and around the complex. If required, the facility will hire a generator in the event of an emergency. Emergency lighting is regularly tested as part of the building warrant of fitness.</p> <p>A call bell system is in place in all patient care areas, and alerts staff to residents requiring assistance. Audits of the call bell system are completed on a regular basis and residents and family members reported staff respond promptly to call bells; this was also observed during the audit.</p> <p>Documented security process are in place, with staff being trained in this role. External lighting come on at night all around the building. External doors and windows are locked at a predetermined time, including the main entrance. All external doors are alarmed. Visitors who wish to enter, alert staff by means of a bell at the main entrance and staff are aware of only allowing entry to people whom they have no concerns about.</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 have external opening windows and all but two have patio doors to the garden areas. Heating is provided by underfloor heating, air conditioning units and a gas fire in the main lounge. The maintenance person, provided copies of regular temperature monitoring. Areas visited 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>There is a current infection prevention and control (IPC) programme and comprehensive infection control manual. These are reviewed annually and cover all areas of service to minimise the risk of infection to residents, staff and visitors.</p> <p>The CNM stated that she has the role of designated IPC coordinator, and this is identified in her job description. Infection control matters, including surveillance results, are discussed at the weekly RN meeting, reported monthly to the GM and to the staff at their ongoing meetings. There is an IPC committee and the CNM reports that the membership did include staff from all areas, however this has proved difficult and it is planned to reboot the membership.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell, not to enter the facility. There is also hand gel available at reception and throughout the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The CNM was able to state safe practice for ill staff and 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 CNM has appropriate skills, knowledge and qualifications for the role, and has been in this role for three years. She has attended external infection prevention and control study days, as verified in training records sighted. She stated that additional support, information and support in the event of infection, is accessed from the infection</p>

		control team at the DHB and through the community laboratory. The CNM has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The 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 2018 and 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>	FA	<p>Infection prevention and control training is part of all staff orientation and is part of the annual training calendar. This was confirmed by the CNM and staff interviewed. This education is provided by suitably qualified RNs, and the CNM. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. There have been no infection outbreaks but there are policies and procedures for staff to follow should this occur.</p> <p>Education with residents is generally on a one-to-one basis and has includes a reminder to handwashing, and to remain in their room if they are unwell.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance undertaken is appropriate to that recommended for long term care facilities and includes a range of infections. Those noted in reports include urinary tract (with or without catheter), soft tissue including eye and lower respiratory tract. The CNM reviews all reported infections and these are documented into the electronic infection control database. New infections and any required management plan are discussed at handover, to ensure early intervention occurs, this was</p>

		<p>confirmed by care staff.</p> <p>The CNM collates infection data is collated and analysed to identify any trends, possible causative factors and required actions. No trends are apparent and the CNM has produced graphs from the electronic system showing infections over time. The system has the ability to benchmark with other providers and this does occur from time to time.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The CNM is also the restraint coordinator and provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, five residents had restraint and three residents had enablers documented as part of their long term care plan. There were the least restrictive means of providing safe care and enablers only used voluntarily at the resident's request. The same 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 in the files reviewed, and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval group, made up of the CNM, RNs, a GP and diversional therapist, is responsible for the approval of the use of restraints and the restraint processes. It was evident from review of resident's files and interviews with the coordinator and staff that there are clear lines of accountability, that all restraint use has been approved. The only form of restraint used is personal restraint. That is holding the resident's hands while performing cares and only for the minimum time required. This process has been introduced since the last audit, and the overall use of restraints is being monitored but it is too early for analysis to occur.</p>

		Evidence of family, with EPOA, involvement in the decision making was on file in each case as part of the consent process. Use of a restraint or an enabler is documented in the resident's plan of care.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the standard. The RN undertakes the initial assessment with input from the resident's EPOA. The CNM and a RN described the documented process and this was sighted in the four files reviewed. The general practitioner (GP) is involved in the final decision on the safety of the use of the restraint and signs the consent form. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised, alternatives to restraints are documented as part of the assessment and discussed with staff and family members. Examples of de-escalation were described on the assessment document. The hand hold restraint is only used while carrying out cares, such as showering or getting the resident ready for bed. This was confirmed by the care givers and RN spoken with.</p> <p>A restraint register is maintained and it is reviewed and updated every three months at the restraint committee meeting.</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>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, three monthly. EPOA's interviewed confirmed involvement with the care plan</p>

		<p>review and their satisfaction with the process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The CNM stated that the use of personal restraint is a recent development, within the last three months. The use and monitoring is discussed at the monthly RN meeting. The data is being collected and monitored and is to be reviewed at the restraint committee meetings three monthly, but this is yet to happen as the use of restraints has only been implemented in the last three to four months.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.2</p> <p>Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.</p>	PA Low	<p>Examples of Enduring Power of Attorney (EPOA) documentation were found in the files of residents in the dementia service. The status of property and welfare EPOAs were noted in the interRAI assessments. Further examples of EPOA status were found in residents' files in the front office where additional personal information is filed. A corrective action has been raised due to the number of anomalies in associated documentation. There were examples in residents' files of named EPOAs but no supporting documentation was available; some had EPOAs named in the file, but there was no evidence they had been activated; there was an example of documentation for an EPOA for property but not welfare;</p>	<p>Not all residents in the dementia service have Enduring Power of Attorney documentation available and the EPOA documentation for some residents that is available has not been activated.</p>	<p>All residents in the dementia service are required to have an Enduring Power of Attorney (EPO A) that has been enacted. Actions to have one appointed, and/or activated, are to be proactively supported.</p> <p>180 days</p>

		<p>one person had an EPOA who is not able to represent the person and there were three people for whom there was no mention of an EPOA. Some of the residents represented within missing or incomplete documentation regarding the enactment of an EPOA had been at the dementia service for more than a year.</p>		
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The service delivery file of a respite care resident in the dementia service was reviewed within the sample of file reviews. Considerable behavioural challenges that are presenting risks to the resident and to others were evident in progress notes; however this person had not been assessed by a relevant specialist and there was no behaviour management plan available to guide staff in the care of this person when their behaviour escalates. The resident had been at the facility for a fortnight; but there were no medical notes indicating a GP or other physician had reviewed this resident either pre or post the admission.</p> <p>Staff reported the person was admitted for reassessment for long term dementia care on the recommendation of the NASC, as the previous NASC assessment was more than a year old. This person is expected to remain at the facility following a reassessment. There was no information about these plans in the file and although there is only one</p>	<p>There was a lack of key documentation in the service delivery file of a respite care resident in the dementia service, which was compromising their safety. There was no evidence of a medical assessment/review, current needs assessment, behaviour management plan, or of the referral or plans for re-assessment regarding long term care.</p>	<p>All residents will have relevant assessments undertaken and care planning instituted at the time of admission, including those receiving respite care services, to ensure safe service provision. This especially relates to the respite care resident in the dementia service, as identified at audit.</p> <p>30 days</p>

		<p>week of the respite stay to go there is no indication in the file as to when the reassessment will occur. A letter from a family member was on file; however, there was no confirmation that an Enduring Power of Attorney had been activated, which is an issue already identified for corrective action in standard 1.1.10.</p> <p>Actions to address the identified shortcomings were commenced at the time of audit, thus reducing the risk level.</p>		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.