

Heartland Care Limited - New Vista

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: Heartland Care Limited

Premises audited: New Vista

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

Dates of audit: Start date: 25 October 2018 End date: 26 October 2018

Proposed changes to current services (if any): Change of ownership. Creation of a new medicine room and a new bedroom from an existing room not in use. This increases the number of bedrooms from 59 to 60.

Total beds occupied across all premises included in the audit on the first day of the audit: 56



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

New Vista Rest Home and Hospital provides rest home and hospital level care for up to 59 residents. The facility is operated by New Vista Rest Home Limited. The service is managed by a facility manager and a clinical manager with support from the quality manager. Residents and families spoke positively about the care provided.

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

This audit also established how well prepared the prospective provider is to provide a health and disability service. A spokes person for Heartland Care Limited was interviewed during this audit. The prospective provider understands the Health and Disability Services Standards and the Age Residential Related Care Agreement, and the appropriate person in the District Health Board has been advised of the change of ownership prior to the provisional audit.

Improvements required from this audit relate to coordination and continuity of care services, review of the menu, temperature checking of incoming frozen/chilled food, a code compliance certificate for the new bedroom and evidence that the current fire evacuation scheme remains approved.

Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected during care and support. Consideration of personal privacy, independence, individuality and dignity were apparent during the daily interaction with residents.

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

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

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

The facility manager and quality manager are responsible for the management of complaints and a complaints register was current. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

New Vista Rest Home Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at New Vista Rest Home and Hospital and include a documented scope, direction, objectives, values, and a mission statement. Systems are in place for monitoring the service, including regular reporting by the facility manager to the owners.

The facility is managed by an experienced facility manager who is an enrolled nurse and has been in this role for six years. The facility manager is supported by a clinical nurse manager and a quality manager. The clinical nurse manager is responsible for the oversight of clinical services in the facility.

Quality and risk management systems are followed. There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, various staff and resident meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks.

Policies and procedures on human resources management are in place and processes are followed. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are always rostered on duty. The clinical nurse manager and facility manager are on call after hours.

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

Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident and their family/whānau.

Registered nurses and a general practitioner assess residents' needs on admission. Care plans are individualised and based on a comprehensive range of assessment information. Changes are made to incorporate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis and in accordance with contractual requirements. Residents with changing health needs were referred to other health services as required.

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

Medicines are safely managed using an electronic system and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A current food safety plan is in place. Residents described their satisfaction with meals.

Safe and appropriate environment

A current building warrant of fitness is displayed. Preventative and reactive maintenance programmes include equipment and electrical checks.

Single accommodation is provided with a mix of shared and single full ensuites provided. Adequate numbers of additional bathrooms and toilets are available. There are several lounges, dining areas and alcoves. External areas for sitting are provided as is shading.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems are audited for effectiveness.

An unused room has been converted into a medicine room and a bedroom.

Restraint minimisation and safe practice

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraint and enablers during the audit. Appropriate documentation was reviewed including a current restraint register.

Infection prevention and control

The infection prevention and control programme is led by a registered nurse who, as the infection control coordinator, has responsibility to oversee the programme and prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice from the district health board is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. There have been no infection outbreaks since the previous audit.

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	46	0	3	1	0	0
Criteria	0	97	0	3	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>New Vista 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 with residents, knocking before entering rooms and offering residents choices throughout their day. Independence was encouraged wherever possible, and the individual resident's privacy maintained during care delivery. Staff training on the Code is included as part of the orientation process and ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent, with comprehensive policies available to guide them. Advance care plans are included where these have been completed previously by the resident. Documentation in relation to enduring power of attorney is on file with an indication of whether these</p>

		<p>have been enacted or not.</p> <p>There has been ongoing development of a more suitable form to gather residents' preference in relation to resuscitation orders and the importance of resident competency. This new format has been implemented, and in all cases demonstrated involvement of the general practitioner. The service is reviewing all such documentation for each resident at the time of their care plan review, to ensure it is current and reflective of the person's ability to give consent Requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed gaining resident consent for day to day care. Most residents who were able to give informed consent did so, prior to the pre-winter flu vaccination programme.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>The resident information pack contains a copy of the Code and brochures on the Advocacy Service. Information about the Code and Advocacy Service are displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. They described how they would first discuss any concerns with the clinical nurse manager.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and maintain links with their family and the community. They achieve this by attending a variety of organised outings, visits, shopping trips, activities, and entertainment, including a group activity involving other rest homes throughout the district. Access is enhanced through the use of the New Vista van which is wheelchair accessible.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family/whānau and friends. Family members interviewed were very closely involved, often visiting for extended periods, and stated they always felt welcome when they visited their relative.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The facility manager (FM) and the quality manager (QM) are responsible for complaints management and follow up. The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and forms available at the entrances to the facility.</p> <p>The complaints register showed 13 complaints have been received since the previous audit. Actions taken, through to an agreed resolution, were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The facility manager and quality manager reported there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</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) as part of the admission information provided at the time of admission. Staff could describe examples where family members were encouraged to participate to ensure the resident felt supported during discussions (eg, during the family meetings held with the GP and team). The Code is displayed in the entrance together with information on advocacy services and feedback forms are available in key areas of the facility.</p> <p>The prospective owner is aware of the Code. Current clinical staff will all transition to the prospective owner. Staff demonstrated a sound understanding of the requirements of the Code.</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 they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room or share a room with their spouse. There are two married couples accommodated in the facility.</p> <p>Residents are encouraged to maintain their independence by attending community activities individually or as part of a group outing. Some residents will attend appointments in the community, such as a dental or optician, often with the support of their family. Care plans included documentation related to the resident's abilities, and strategies to maximise independence, including for short-term residents undertaking rehabilitation on the intermediate care or non-weight bearing contract.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Interdenominational church services are offered in the facility for those who wish to attend. A social history completed on admission assists staff in identifying individual psychosocial needs and preferences.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education has been completed on the topic of abuse and neglect.</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>Currently, there are two residents who identify as Māori. Their plans of care reflected their cultural values and beliefs and the level of support they prefer. One resident enjoys strong whānau support, with good evidence of their significance and engagement with the resident on an ongoing basis. A Māori health plan reflected the principles of the Treaty of Waitangi is implemented into daily practice. There is guidance on tikanga best practices. Staff interviewed had good understanding of these individual residents' needs.</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>	<p>FA</p>	<p>Both residents and their family/whānau verified during interviews, that they were consulted on their individual culture, values and beliefs and that staff respected these during care delivery. Staff have a good understanding of what this entails. The interviews also confirmed that any issues or concerns were readily addressed by the staff, with a high level of confidence that any issues would be addressed promptly. Where a resident expressed personal preferences in relation to their personal values, clothing, food choices or level of involvement, this was seen to be respected. However, there are some care plans which lack detail (see 1.3.3.4). The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed confirmed they had not experienced discrimination and felt safe within the facility.</p> <p>Staff orientation includes education related to professional boundaries, expected behaviours (house rules), and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures, employment agreements and demonstrated a clear understanding of how they would report inappropriate behaviours.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through maintaining evidence-based practices such as attendance and training for staff in programmes such as “walking in another’s shoes”. External specialist services and allied health professionals, for example, Whanganui Hospice team, a diabetes nurse specialist, wound care nurse specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the availability of specialist services including the psychogeriatrician when required. Staff interviewed stated they felt able to request additional support from external services if necessary.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary</p>

		<p>good practice.</p> <p>Other examples of good practice observed during the audit included improvements which are currently being made to the documentation related to advance directives.</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 were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Two family members interviewed reported excellent communication and a sense their opinions were considered when caring for their relative. The recent involvement of the house doctor in regular family meetings has been an excellent initiative. Staff stated that the GP is proactive in meeting residents and family. Documentation reviewed demonstrated regular family contacts in relation to any adverse events or accidents for their relative, as well as for appointments and feedback from doctors' visits. Each family member completes a preferred level of contact form to ensure they get the kind of information they wish. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required. One non-English speaking resident has strong support from family and the use of cue cards in day-to-day care. The clinical nurse manager reported that interpreter services are available by contacting the local DHB, although this has not been required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>New Vista Rest Home Limited is responsible for the services provided. A business plan 2017-2019 was reviewed that includes six key areas, a mission statement, vision, purpose and objectives.</p> <p>The facility manager who is an enrolled nurse (EN) has been in their current position since 2012 and prior to this appointment managed other aged care facilities. The management of clinical services is the responsibility of the clinical nurse manager (CNM) who has been in</p>

	<p>their role since July 2015. Prior to this the CNM was employed as an RN at New Vista. The annual practising certificates for the facility manager and clinical nurse manager are current. There was evidence on the facility manager's and clinical nurse manager's files of appropriate ongoing education.</p> <p>Monthly manager's reports to the current owners were reviewed and evidenced they are comprehensive and cover all activities associated with New Vista. The prospective owner stated reporting will continue monthly with the prospective owner spending two day per fortnight with the management team on site with 'Skyping' occurring weekly.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>The prospective provider, Heartland Care Limited consists of two owners/directors. Although the prospective owners are new to the aged care sector they both have experience in business management. One of the prospective owners interviewed on site has a background in health management with eight years' experience. Other experience includes, but is not limited to, strategic planning and monitoring, evaluation and research and as a public health practitioner. The prospective owner has a masters degree in both public health and evaluation and is an accountant and a solicitor. The other prospective owner is a veterinarian who has experience in managing a business.</p> <p>A transition plan reviewed and interview of the prospective owner and the current owners evidenced the current owners are committed to providing a comprehensive handover during the transition period until the 5 December 2018 when the prospective provider take ownership. The senior management team will remain in place and existing staff will transfer to the new provider. The prospective owners will provide governance and management support to the New Vista management team. The prospective owners have notified the District Health Board prior to the provisional audit being undertaken.</p> <p>New Vista occupancy on the first day of the audit consisted of 56 residents, 30 assessed as rest home level including one resident under the age of 65 years and one resident under the intermediate contract. Twenty-six residents have been assessed as requiring hospital level</p>
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		<p>care including one resident under the age of 65 years and one resident in for respite care.</p> <p>Apart from bedrooms 22, 23, and 44 which are small and for rest home residents only, all other rooms have been approved as dual purpose. The new bedroom (room 58) is suitable for rest home level care.</p> <p>The service provider has funding contracts with the district health board (DHB) to provide aged related residential care, long term support chronic health conditions – residential, intermediate care services, carer relief and a dedicated respite bed.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The CNM and the QM fill in for the FM when they are temporarily absent. When the CNM is absent, a senior RN/team leader fills the role.</p> <p>The prospective owners are not planning any changes. Existing cover arrangements for the day to day operation will remain in place. The prospective owner understood the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.</p> <p>The FM reported the reconfiguration will have no impact on the day to day management.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality improvement and risk management plan guide the quality programme and includes a mission, quality commitment, objectives and quality principles. An internal audit programme is in place and internal audits completed for 2018 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk.</p> <p>Quality, RNs/ENs, health and safety, restraint and infection prevention and control combined meetings and full staff meetings are held monthly. A three-monthly newsletter for staff is provided that includes</p>

	<p>minutes of meetings. Residents' meetings include topics of interest. Meeting minutes, including quality data, are available in the nurses' stations for staff to read and sign off. Meeting minutes evidenced reporting of completed internal audits, quality data, including clinical indicators which are graphed. The quality manager is experienced in quality and risk management processes and is responsible for ensuring the organisation's quality and risk management systems are maintained.</p> <p>Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed. There was documented evidence quality improvement data is being collected, collated, comprehensively analysed and reported. Quality improvement data included adverse event forms, internal audits, meeting minutes satisfaction surveys, infection rates and health and safety. Corrective action plans are being developed, implemented, monitored and signed off as being completed.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. The 'Lifestyle Care Plan Policy' includes interRAI requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed they are advised of updated policies and that they provide appropriate guidance for service delivery.</p> <p>A Health and Safety Manual is available that includes relevant policies and procedures. Actual and potential risks are identified associated with human resources management, legislative compliance, contractual and clinical risk. The hazard register identifies hazards and evidenced the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The quality manager (QM) is the health and safety coordinator and is responsible for hazards. The QM demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.</p> <p>The prospective provider advised the current policies and procedures</p>
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		<p>will remain the same with the change of ownership. The current quality and risk management plan will remain. In the New Year the prospective owner reported they plan to review the plan with the management team.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form including a complete neurological observation form and falls risk assessments completed following accidents/incidents as appropriate. These are collated by the facility manager and quality manager. The originals are kept in the residents' files. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. The satisfaction surveys confirmed this.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM and QM advised there have not been any essential notifications made to the Ministry of Health or other external agencies since the previous audit.</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. A wall forming part of a new bedroom is currently being upgraded to a fire rated wall before a Code Compliance Certificate can be issued by the local authority. The current owners confirmed they have taken responsibility for this (See criterion 1.4.2.1).</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>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>The education programme is the responsibility of the FM and QM. In-service education is provided for staff in several ways including monthly sessions, 'tool box' talks at shift handover, specific topics relating to resident's health status, three monthly staff newsletters and staff meetings. The local DHB also provides an education programme for both RNs and caregivers and staff have also attended other external education. Individual records of education are held on staff files and electronically. Competencies were current including but not limited to medicines, restraint, manual handling, challenging behaviours, cultural safety, pressure injury and falls. Attendance records are maintained. Five RNs are interRAI trained and have current competencies including the CNM.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. The FM is the assessor for the facility.</p> <p>An orientation/induction programme is comprehensive and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers all essential components of the service provided.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice. Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p> <p>The reconfiguration will have no impact on human resources management.</p>
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<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. An electronic programme, 'Model of Care' is used that is based on best practice. The FM and CSM reported they review the rosters weekly and consider dependency levels of residents and the physical environment. There are two RNs and nine caregivers rostered on the morning shift, plus the CNM who works full time Tuesdays to Saturdays inclusive. One RN, either another RN or an EN work on the afternoon shift with six caregivers. One RN and two caregivers are on the night shift. There are dedicated cleaners and laundry staff.</p> <p>The FM and CNM are on-call after hours. Care staff interviewed reported there is adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided.</p> <p>The prospective owners intend to maintain the current staffing levels and skill mix. The prospective owner stated the electronic 'Model of care' programme will remain as well as the 'Staffing Rationale policy'. The prospective owner understood the required skill mix to ensure hospital and rest home residents' needs are met.</p> <p>The FM reported the roster will not change as a result of the creation of one new bedroom.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Resident information is collected from admission onwards. It includes essential demographic, personal clinical and health information which is held in an organised, integrated hard copy file.</p> <p>In 17 files reviewed, all necessary demographic, personal, clinical and health information was fully completed. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Clinical notes were current and integrated with GP medical notes, however it is noted that there are no</p>

		<p>progress notes maintained from the activities team. (See comments 1.3.3.4). Medication records are held securely within the electronic system.</p> <p>Archived records are held securely on site and are readily retrievable if required.</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, with residents' files stored securely when not in use by staff.</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 are assessed prior to entry to either the hospital or rest home service. The scope of the service and contracts held is known to referrers.</p> <p>For permanent care, residents are assessed, and the level confirmed by the needs assessment and service coordination (NASc) service. Prospective residents and their family/whānau are encouraged to visit the facility prior to entry. Detailed written information is provided. The organisation seeks updated information from NASc, the GP and pharmacy for residents accessing respite care. Staff stated they take extra care to ensure current information for respite residents is available.</p> <p>One family member interviewed stated they were satisfied with the admission process for their relative which had occurred earlier in 2018 and the information provided ensured they were well-informed at entry. Files reviewed contained completed demographic detail, assessments and all had current signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort provided or family member accompanying the resident, as appropriate. Comprehensive information is sent with the resident, including a verbal handover where possible. Medication</p>

		<p>records are printed from the electronic system and any other relevant information, such as advance care planning or enduring power of attorney records, to ensure ongoing management of the resident. A family member interviewed confirmed the resident had previously been transferred to the secondary care service on a number of different occasions, and that this had been well managed by the service, with good communication throughout. Referrals are documented in the progress notes.</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>In mid-2017, New Vista Rest Home and Hospital transitioned to an electronic medication management system. Policies were updated to reflect the change requirements. These outline all aspects of medication management consistent with those outlined in this the Medicines Care Guide for Residential Aged Care. Staff report this has been an excellent move, and they feel confident in using a system which is always up-to-date and easy to follow.</p> <p>The medicine management process was observed on the days of audit in both the rest home and hospital areas. The registered nurses 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. Care staff who work night are trained and competent to be the second signing staff member for controlled drugs.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescriptions on arrival. All medications sighted were within current use by dates, including dating of eye drops and ear drops. Clinical pharmacist input is provided on site on request.</p> <p>Controlled drugs are stored securely in a shared medication storage room in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and included completed and accurate entries. The medication room has been altered since the previous audit and is not yet completed. However,</p>

		<p>drugs are securely maintained, fridge temperatures monitored and maintained at the correct temperatures and the area maintained in a clean and tidy state.</p> <p>Good prescribing practices noted include current allergies on all charts, and the prescriber's authorisation and date recorded on the commencement and discontinuation of medicines. All requirements for pro re nata (PRN) medicines were included. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used, and verbal orders not required as immediate prescribing can occur within the electronic system.</p> <p>There is one resident who self-administers their inhalers at the time of audit. A competency assessment has been undertaken and documented. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There are a few medication errors, however should these occur, there is implemented and competent process to ensure investigation and analysis occurs.</p> <p>The reconfiguration will not impact on the management of medicines.</p>
<p>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.</p>	<p>PA Low</p>	<p>The food service is provided on site by an experienced and trained cook and a team of kitchen assistants. The menu is in line with recognised nutritional guidelines for older people and overdue for review. Arrangements are in place for a dietician to complete this in November 2018. The menu follows summer and winter patterns and includes a diary of any changes.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines, except for consistent recording of the temperature of incoming chilled and frozen goods from suppliers (see 1.3.13.5). The service operates with an approved food safety plan and registration issued by 7 March 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has completed a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p>

		<p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, birthdays list, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment and products, to meet resident's nutritional needs, were available.</p> <p>Evidence of resident satisfaction with meals is reported by residents and family/whānau 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.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for a reassessment is made to NASC. Both the GP and clinical nurse manager stated this needed very sensitive handling with family members, particularly for residents who have been at the facility for an extended period. Examples of this occurring were discussed and occurred on the day of audit. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>In addition to the interRAI assessment tool, information is documented using validated nursing assessment tools such as pain scale, falls risk and skin integrity, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of five trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process and felt this was a strength of the organisation.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed are sufficiently detailed to reflect the support needs of residents, the outcomes of the integrated assessment processes and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed, however there are poor linkages between nursing care plan and the activities plan to provide a comprehensive, integrated overview of care needs. (See 1.3.3.4).</p> <p>Progress notes completed by care staff and registered nurses, together with medical and allied health professionals' notations, are clearly written, informative and are relevant and up-to-date. Activities staff do not write in integrated progress notes. (See 1.3.3.4). Short-term plans are developed and implemented appropriately. Changes in care requirements are documented and verbally passed on to relevant staff which. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care 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. Care staff confirmed that documentation provided sufficient information for them to deliver the necessary care.</p> <p>A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. A visiting occupational therapist and physiotherapist attending an intermediate care resident, confirmed staff were delivering care as outlined in their plan. In a further example of effective service delivery, a resident with a grade 2 non-facility acquired pressure injury has a detailed wound plan, with regular interventions occurring and clearly recorded. Documentation, planning and service delivery in relation to this injury was thoroughly documented and consistent with best practice.</p> <p>Interview with the general practitioner responsible for most residents in the facility confirmed that the New Vista Rest Home and Hospital has a stable team providing care. Staff are responsive to medical requests and calls are made to medical staff appropriately and in a timely</p>

		<p>manner. This may be by email or text message. The GP seeks additional support from a psychogeriatrician or refers to other health professionals when required, and has been, overall, very satisfied with the care provided in the facility.</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>	<p>FA</p>	<p>The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy, and an assistant activities coordinator. On occasion, the service may use volunteers for outings, but this is infrequent. There are 60 hours of planned activities allocated across the facility, with the two staff working collaboratively to ensure both group and individual needs are addressed. Individual, group activities and regular events are offered in the programme sighted. External entertainers also provide music and other activities.</p> <p>Activities planning occurs through a social assessment on admission to ascertain residents' needs, interests, abilities and social requirements, a brief plan of care which includes goals, interventions and evaluation and an attendance sheet showing levels of participation. The resident's activity needs are evaluated as part of the formal six-monthly care plan review, with changes made as necessary.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, direct feedback and evaluation of participation. Residents interviewed confirmed they find the programme enjoyable, although not all actively participate, due to changing levels of acuity. There are plans to provide a more suitable area for residents to participate without having to 'pack up' at the end of each session.</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 by care staff. If any change is noted, it is reported to the registered nurse.</p> <p>Formal care plan evaluations consistently occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected,</p>

		<p>the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed was evident in several of the care plans reviewed. Progress is evaluated as clinically indicated when changes occur, such as one of the residents reviewed in detail experiencing weight loss. If necessary, the long-term care plan is also reviewed and updated to reflect the current situation. Family members interviewed are also involved in care plan review through the annual multidisciplinary meeting.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Examples of referrals were sighted in residents' records. If the need for other non-urgent services are indicated or requested, the GP sends a referral to seek specialist input, such as to the wound care nurse specialist or hospice team. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as calling an ambulance for assessment and treatment at accident and emergency if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current.</p> <p>Protective clothing and equipment were sighted in the sluice room and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	PA Low	<p>A current building warrant of fitness is displayed that expires 22 June 2019. There are appropriate systems in place to ensure the residents'</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>physical environment and facilities are fit for their purpose. Apart from one small area, the facility is spacious and passage-ways are wide. Residents confirmed they can move freely around the facility and that the accommodation meets their needs.</p> <p>There is a proactive and reactive maintenance programme and the buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by maintenance person. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current.</p> <p>There are external areas available that are maintained to an adequate standard and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p> <p>The prospective owner stated there are currently no plans for any environmental changes in the facility.</p> <p>A new medicines room and a new bedroom have been created from a room not used. The current owner advised they had not notified HealthCERT of the reconfiguration and advised they would do so during the audit. The local authority has inspected the conversion and requires the exiting wall in the bedroom to be fire proofed. The bedroom is suitable for rest home use only and is fit for purpose.</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>	<p>FA</p>	<p>Bedrooms have a mix of no ensuites, full ensuites and shared full ensuites. There are adequate numbers of additional bathrooms and toilets throughout the facility. Residents and families reported that there are enough toilets and they are easy to access.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote residents' independence.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All bedrooms are spacious apart from three rooms in an area that is the original design. There is personal space provided for residents and staff to move safely around in all the bedrooms. Residents and families spoke positively about their or their relative's accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is adequate room in the facility to store mobility aids such as mobility scooters, wheelchairs and walkers.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Areas are provided for residents to frequent for activities, dining, relaxing and for privacy. Residents, families and staff confirmed and observation evidenced these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is washed on site. Residents and families reported the laundry is managed well and residents' clothes are returned in a timely manner.</p> <p>Dedicated cleaners and laundry staff have received appropriate education. The cleaners and laundry person demonstrated a sound knowledge of processes. The facility is cleaned to a high standard and residents, families and the results from the 2018 satisfaction survey confirmed this. Chemicals are stored securely with a closed system used. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>The current fire evacuation plan was approved by the New Zealand Fire Service on 30 May 2017. There was no evidence from the New Zealand Fire Service that the current fire evacuation plan remains approved as a result of the reconfiguration. There is an evacuation</p>

		<p>policy on emergency and security situations that covers all service groups at the facility. A fire drill takes place six-monthly. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted and all equipment had been checked within required timeframes.</p> <p>There is always at least one staff member on duty with a current first aid certificate.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs. Back up battery powered lighting is available should there be a power outage.</p> <p>There are call bells to alert staff.</p> <p>Contractors must sign in and out of the facility. The external doors are locked in the early evenings. Sensor lights are situation externally and the RN on the PM and night shifts carry out internal rounds of the facility.</p> <p>The prospective owner advised there are no plans for environmental changes to the service.</p> <p>The new bedroom has a call bell in place.</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>	<p>FA</p>	<p>Heating is provided by heat pumps and gas under floor and ducted through the ceilings. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. There is a covered external area for smokers.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>visitors. The programme is guided by a comprehensive and current infection control manual from a commercial source, with input from specialist infection prevention and control staff at the DHB if required. The infection control programme is reviewed annually.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are clearly defined in a role description. Infection control matters, including surveillance results, are reported monthly to the clinical nurse manager and quality coordinator and tabled at the quality and risk surveillance results and graphed details by infection type per 1000 occupied bed days. There is a low rate of infection recorded.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. There is hand hygiene gel available at the entrance and in clinical areas. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator has undertaken training for the role through attendance at IPC sessions offered by the DHB – this was verified in education records sighted and includes education relevant to an aged care facility. She is booked on a further session in early November 2018. She has gained appropriate skills and knowledge in this role over the past two years. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and other specialist sources. Examples were discussed where advice had been sought. The IPC coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. There have been no infection outbreaks since the previous audit.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. Adequate supplies of personal protective equipment were evident throughout the facility.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. The service utilises a commercially available manual customised for the New Zealand environment for its infection control policies and procedures. Customised procedures are added where necessary such as in relation to cleaning. The service is awaiting delivery of an updated manual. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, suitable 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 and could describe the use of gloves and handling or disposal of contaminated items.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews with care staff and residents, observation of practice and documentation verified staff have received education in infection prevention and control at orientation and that ongoing education sessions, including standard precautions, are provided. Education is provided by registered nurses and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Regular audits of hand hygiene practices are undertaken, and records of competency maintained. When an increase in the rate of infections occurs, this is investigated, and additional training provided in response. This occurred when one resident required precautions related to an airborne infection.</p> <p>Education with residents is generally on a one-to-one basis and most commonly relates to reminders about handwashing and increasing fluids during hot weather. Unwell residents are discouraged from leaving their rooms.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin and soft</p>

<p>objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>tissue, fungal, eye, gastro-intestinal, and the upper and lower respiratory tract.</p> <p>The IPC coordinator reviews all infections reported in the system and these are collated and graphed by the quality coordinator to provide an opportunity to view trends through monthly data analysis and graphs. Few infections are reported in any category in the facility, and the small numbers make comparisons difficult. However, there is sufficient data year on year to indicate low rates of infection occur. New infections and any required management plan are discussed at handover, and short-term care plans developed to manage any new resident infection. The organisation does not contribute to any external benchmarking programme.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service demonstrated that the use of restraint is actively minimised. There were six residents using restraint and two residents using an enabler during the audit. The restraint coordinator is the FM and demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register was current and updated. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two.</p> <p>The restraint approval group forms part of the quality meetings. Restraint is also an agenda item at the staff meetings. Meeting minutes and staff confirmed this.</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>	<p>FA</p>	<p>The use of restraint is approved by the restraint approval group prior to commencing the restraint, this includes the resident's GP. The GP completes three-monthly reviews of restraints in use. A signed job description for the restraint coordinator was evident in the FM's file and in the restraint folder. Responsibilities of the restraint coordinator and approval group are clearly outlined.</p> <p>Restraint use is discussed in the quality and staff meetings. Staff confirmed their knowledge of the restraint processes.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Files of residents using restraint were reviewed. Restraint assessment forms were completed prior to commencing restraint. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. Long term care plans clearly documented any risk and desired outcomes. Staff demonstrated good knowledge in maintaining culturally safe practice when completing assessments for restraint use.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Restraint minimisation policies and procedures are accessible for all staff to read. Safe use of restraint is actively promoted. There was a current and updated restraint/enabler register. The management plans include any risk factors and ensures the resident's safety while using restraint. Staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. There were no restraint-related injuries reported. Monitoring forms are in place for all residents who are using restraint and these were completed as required.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Residents using restraints and enablers are evaluated at least three-monthly and the resident's care plan six monthly. Consents and evaluation forms were signed by the GP and the resident's family/EPOA. The evaluation form included the effectiveness of the restraint and the risk management plans documented in the long-term care plans. Staff confirmed their feedback was obtained by the restraint coordinator when evaluating the restraint in use. The restraint approval group evaluated the restraints in use at least three-monthly. Meeting minutes confirmed this.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint approval group is responsible for monitoring and reviewing restraint. Quality review of restraint is monitored through the internal audit programme. Identified issues are discussed at the quality and staff meetings as well as additional education that is required to</p>

		support staff. This includes education relating to restraint and challenging behaviour. Staff demonstrated sound knowledge relating to managing challenging behaviours. Equipment such as sensor mats and low-low beds are used to minimise the use of restraint.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>New Vista Rest Home and Hospital has a four-weekly menu cycle reflecting a summer and winter pattern. This was last reviewed in September 2016. Email evidence of arrangements for this to be completed were sighted and the review is underway by a registered dietician.</p> <p>A food safety plan has been approved and audited. At the time of that audit, there were anomalies in the records of monitoring of temperatures of incoming chilled and frozen food items. Inspection of current records indicates these anomalies are still occurring, particularly where food is delivered later in the day, or there are relieving kitchen staff covering the shift.</p>	<p>1. The menu review for the facility is now overdue. Emails sighted between the service and the dietician indicate this is in process and should be completed in November 2018.</p> <p>2. Temperature checking of incoming chilled and/or frozen food is not reliably undertaken for all incoming goods received into the kitchen.</p>	<p>Complete the bi-annual menu review and implement consistent recording of all incoming chilled and frozen food in accordance with the food safety plan.</p> <p>180 days</p>

<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>Coordination of services does not always ensure there is continuity and a team approach. Examples were noted where there are poor links between assessment, planning, provision, evaluation and review in both nursing and planned activity documentation. File reviews for ten residents indicates that:</p> <ol style="list-style-type: none"> 1. There is no recognition of the specific and differing needs of a married couple who share a room and living space. The specific needs of each partner are not formally assessed or planned for through their nursing care or activities plans. 2. Not all interventions to meet assessed needs are documented. One individual has cultural needs which, although documented, have not been planned for. However, it is reported that actions have been taken to meet this need. 3. The diversional therapist and activities coordinator do not record resident progress detail in the integrated progress records to support evaluation of their individual plan. 4. Multidisciplinary collaboration is not always evident when planning care. Lack of contribution by all team members to care plan review leads, on four occasions in the sampled files, to disparity between nursing care plans and individualised activity plans. 5. Residents with an increasing dementia are present in the facility and their increasing support needs are apparent. While there have been discussions with both the families and the GP about these changing needs, and ongoing 	<p>Coordination of services does not always ensure there is continuity and a team approach. Examples were noted where there were poor links between assessment, planning, provision of support, evaluation and review in both nursing and planned activity documentation designed to support integrated and coordinated care.</p>	<p>Ensure there is a documented system which demonstrates co-ordination and integration of all aspects of individualised care planning.</p> <p>90 days</p>
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		requirements, there is some delay in planning to ensure the ongoing safety of the individual resident and of other residents in the facility.		
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>A current building warrant of fitness is displayed in the facility. A room that was not used has been converted into a medicines room and a bedroom (room 58) by installing a wall down the middle of the exiting room. The current owner advised they were unaware they required a building consent at the time of the renovation. The local authority has inspected the conversion and requires the existing wall in the bedroom to be upgraded to a fire rated wall prior to a code compliance certificate being issued. The bedroom has a call bell and panel heater with an outlook to the internal court yard. The room is fit for purpose and is suitable for rest home level care only.</p>	<p>A disused room has been converted into a medicines room and a bedroom (room 58) by installing a wall down the middle of the exiting room. The local authority requires the exiting wall in the bedroom to be upgraded to a fire rated wall before a code compliance certificate can be issued.</p>	<p>Provide evidence that a code compliance certificate has been issued for the new bedroom before the room is occupied.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	<p>The current fire evacuation scheme was approved by the New Zealand Fire Service (NZFS) on the 30 May 2017. There was no evidence available from the NZFS that the current fire evacuation scheme remains approved as a result of the creation of a new bedroom and the requirement of one wall to be upgraded to a fire rated wall.</p>	<p>Evidence was not available to indicate that the current fire evacuation scheme remains approved following the creation of a new bedroom which requires one wall to be fire rated.</p>	<p>Provide evidence from the NZFS that the current fire evacuation scheme remains approved as a result of the reconfiguration.</p> <p>Prior to occupancy days</p>

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.