

# Heritage Lifecare limited - Cantabria Lifecare

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Heritage Lifecare Limited
<b>Premises audited:</b>	Cantabria Lifecare
<b>Services audited:</b>	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
<b>Dates of audit:</b>	Start date: 13 November 2018      End date: 14 November 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	139



# Executive summary of the audit

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## Introduction

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

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

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Cantabria Lifecare provides rest home, hospital and dementia level care for up to 236 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and an assistant facility manager/clinical services manager. Residents and families expressed satisfaction about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The service also holds a contract with the Ministry of Health for young persons with disabilities. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, two general practitioners and a nurse practitioner.

This audit has resulted in corrective actions related to a range of staff training issues including the need for three-month new staff appraisals, ensuring the roster reflects who is working night shift in the hospital and dementia services, monitoring medication fridge temperatures and the process for medicine self-administration and the need for hazardous substances to be kept safe at all times.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Standards applicable to this service fully attained.

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

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

Residents who identify as Maori have their individual needs met in a manner that respects their cultural values and beliefs. Care is guided by the organisation's Maori Health Plan and related policies and procedures. There was no evidence of abuse, discrimination or neglect. Professional boundaries are understood by staff and maintained.

Open communication between staff, residents and families is encouraged and confirmed to be effective. Interpreter services are accessible.

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

Information about complaints is readily available. The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Heritage Lifecare Limited is the governing body and is responsible for the service provided at this facility. A strategic plan is in place as are separate business and quality and risk management plans. These include the scope, direction, goals, values and mission statement of the organisation. Systems are in place for monitoring the services provided, including regular monthly reporting by the facility manager to the governing body via senior management at support office. The facility is managed by an experienced and suitably qualified manager who is supported by an assistant facility/clinical services manager who is a registered health professional.

A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where necessary. Quality improvement projects are emerging to address identified shortfalls, or opportunities for improvement. Meeting minutes, reports and graphs of clinical and key performance indicators are documented.

Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated. Both the risk and hazard registers are up to date.

A suite of policies and procedures have been approved and issued by the governing body. These documents cover the necessary areas, were current and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. There is a comprehensive orientation programme that includes 'buddying' for new staff. A staff training schedule has been developed and staff training sessions are being provided.

Overall, staffing levels meet contractual requirements and the changing needs of residents. The managers share responsibilities for responding to enquiries out of hours, depending on the nature of the enquiry.

Residents' information is accurately recorded, securely stored and is not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using an integrated hardcopy record.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

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

Medication policy identifies current best practice for medication management. Staff who administer medication have completed a medication competency in the last 12 months.

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

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The facility is in two main buildings, one referred to as the hospital and the other the rest home. These were built at different stages. A dementia unit is downstairs in the rest home building. All residents have their own room, except for one couple who share. Some rooms have an ensuite, some have a shared ensuite and some use a common bathroom. Bedrooms and bathrooms are of adequate size to provide personal care.

All building and plant comply with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented. Appropriate equipment and appliance checks are being completed.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external garden and courtyard areas with seating are available.

Policies guide the management of waste and hazardous substances. Protective equipment and clothing are provided and used by staff. All laundry is undertaken in one of two laundries. Systems are in place to monitor the effectiveness of cleaning and laundry processes.

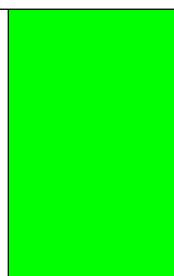
Emergency procedures are documented and displayed. Regular fire drills are completed, there is a sprinkler system installed and call points have been identified in case of fire. Access to an emergency power source is available. A call bell system is in place and a contracted security company monitors the facility each night.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Three enablers and nine restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme is led by an experienced registered nurse and committee who aim to prevent and manage infections. Infection prevention and control advice can be sought from the district health board. The programme is reviewed annually, and objectives are set.

Staff demonstrated sound knowledge and good principles and practice around infection control. Policies and procedures are accessible on-line. Education is provided for all staff at orientation and training is ongoing.

Aged care specific infection surveillance is undertaken, data is analysed and trended and results are reported back to staff and through all levels of the organisation. Follow-up action is taken as and when needed.

## 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	96	0	4	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>Cantabria Lifecare utilises Heritage Lifecare Limited's organisational policies, procedures and processes to meet their 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>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical records reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including consent for photograph release, outings, names on door, personal care, healthcare, emergency care by staff and the collection and sharing of health information. At the first medical assessment the cardiopulmonary resuscitation form, do not resuscitate/serious illness form is signed. At appropriate times the following forms may be obtained: the generic treatment/procedure signing form; and the influenza vaccination form.</p> <p>Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident's record. All residents entering the dementia care service have an enacted EPOA (refer to 1.3.1). Staff</p>

		<p>demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis. Informed consent training is provided to clinical staff annually as part of the Code of Rights training package.</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>During the admission process, residents are given a copy of the Code which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were also displayed 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.</p> <p>Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed.</p> <p>The Chaplain regularly visits the facility. The Chaplain can advocate and deal with concerns that the residents are not comfortable to deal with. Any concerns residents or family members have are dealt with promptly by the facility manager or unit coordinators.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities and entertainment.</p> <p>Cantabria Lifecare has unrestricted visiting hours and encourages visits from residents' family/whanau and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff.</p> <p>Advocacy training is provided to all staff annually every February and July as per the training records reviewed. The community nurse practitioner visits on a regular basis.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints and concerns policy, flowchart and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and family members. Complaints information and forms are available from reception.</p> <p>The complaints register was reviewed and showed that a total of 77 compliments and 40 complaints have been lodged since February when ownership changed. This register is continuous, as per HLL policy, rather than annual. All recorded complaints showed that actions had been taken, through to an agreed resolution and completed within the timeframes specified in the Code. Documented action plans showed required follow up and improvements have been made where relevant. It was observed that in addition to formal complaints, concerns raised are also being recorded in the register and addressed appropriately.</p>

		<p>Except for several additional complaints in July, numbers have been progressively reducing since February.</p> <p>The facility manager is responsible for complaints management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and caregivers informed they would report any complaints they receive to a senior staff person.</p> <p>One complaint is currently under investigation by the Health and Disability Commissioner. Responses have been forwarded when requested and all related correspondence was filed. The issue is not related to the care and support of current residents.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<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, discussion with staff and by ongoing discussion with the facility resident advocate and Chaplain. Information on the Code, the advocacy service, how to make a complaint and feedback forms were displayed in all service areas.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff interviewed understood the need to maintain privacy and were observed doing so throughout the audit when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and enabling residents' privacy for discussions.</p> <p>Residents are encouraged to maintain their independence by involvement in community activities, and participation in work programmes for younger disabled (YPD) residents. Each care plan included documentation related to the resident's abilities and strategies to maintain independence as much as possible.</p> <p>Records reviewed confirmed that each resident's individual culture, religious and social needs, values and beliefs had been identified, documented and incorporated into their individual care plan.</p> <p>Staff interviewed 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 (February and August 2018), as confirmed by staff and the training records.</p>
<p>Standard 1.1.4: Recognition Of</p>	FA	<p>Staff support a number of residents who identify as Maori (eight residents identify as Maori) to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day</p>

<p><b>Māori Values And Beliefs</b></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>practice, as is the importance of whanau to Maori residents. There is a current cultural assessment for all residents who identify as Maori that includes a holistic model of Maoridom (Te Whare Tapa Wha). Current access to resources includes the contact details of local cultural advisers in the community. Advice can be sought if needed from the Lakes District Health Board (LDHB) if needed. Guidance on tikanga best practice is available and is supported by the staff who identify as Maori (19 staff identify as Maori) in the facility. Interview with a resident who identified as Maori verified that staff acknowledged and respected individual cultural needs. The Heritage Lifecare Limited Maori Health Plan was reviewed and meets requirements.</p>
<p><b>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</b></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 respected these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. Residents' satisfaction surveys include evaluation of how well residents' cultural needs are met and this supported that individual needs are being effectively met. The resident Chaplain resides in the Cantabria village which is in close proximity to the rest home, dementia service and the hospital wings.</p>
<p><b>Standard 1.1.7: Discrimination</b></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. The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. This is also documented in the employment pack for new staff and in the house rules for the organisation and in the individual employment agreement. Ongoing education is also provided on an annual basis which was confirmed in staff training records reviewed during the audit. Staff are guided by policies and procedures and when interviewed demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p><b>Standard 1.1.8: Good Practice</b></p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through access to online education, evidenced based policies; input from external specialist services and allied health professionals for example the geriatricians, dietitian, mental health services for older people, palliative care team, district nurses, mental health services for older persons and education of staff. Two general practitioners and one nurse practitioner were interviewed. The nurse practitioner provides advice and some in-service education for staff. The two general practitioners interviewed confirmed the service sought advice and appropriate medical intervention</p>

		<p>when required and were mostly responsive to medical requests. The two general practitioners and the nurse practitioner all commented on the significant loss of experienced nursing staff since the previous audit making effective communication an issue at times until newly employed registered nurses gain more experience.</p> <p>Staff reported they receive management support for external education and access their own online learning with guidance from management. Additional resource manuals are available for the registered nurses such as information for infection prevention and control and wound care management.</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 relative's health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was well supported in the residents' records reviewed. There was also evidence of resident/family/whanau input into the care planning process. Staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code. The open disclosure policy was recently reviewed 08 November 2018.</p> <p>Interpreter services can be accessed from the Lakes District Health Board when required. Staff knew how to do so although reported this was rarely required due to all present residents being able to speak English. Staff can provide translation as and when needed, use family/whanau members and communication cards for a resident if they are unable to speak. Staff were observed communicating effectively with residents and family/whanau.</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>Cantabria Lifecare provides hospital, rest home and dementia level care and services for people on the young people with intellectual and/or physical disabilities contract (YPD). On 1 February 2018, it commenced as one of more than 30 sites operated by Heritage Lifecare Limited (HLL). Heritage Lifecare Limited has a vision and mission statement related to continued pursuit of excellence in care and refers to respecting, and valuing residents, families and staff. Five underlying values are described and alongside the mission statement are integrated into a document described as 'The Heritage Way'. All staff are required to sign they have read and understood 'The Heritage Way' when they commence employment. A manager from HLL was present during the audit and discussed management processes and expectations.</p> <p>There is an overarching HLL strategic plan, which includes strategic direction objectives, all of which have key actions and measurements. A Cantabria specific business plan 2018 – 2019 was also sighted. The latter includes six goals for the business for 12 months, operational objectives and site-specific objectives, which are reviewed annually. The facility manager provides a monthly report against the objectives to the senior management team at HLL. A sample of three reports reviewed showed adequate information to monitor performance is reported. These included finances, occupancy, staff retention, administrative and</p>

		<p>monitoring functions and continuous quality improvement.</p> <p>The facility manager has been at Cantabria Lifecare for five months. This person has had experience in management over 39 years, initially in hospitality and in 2009 moved into aged care. Ongoing professional development has included attending regional conferences of a former employer, health and safety seminars and training, leadership training, emergency management and attendance at local DHB aged residential care meetings. Details of the role, responsibilities and accountabilities are defined in a job description and an individual employment agreement, although the latter was not sighted as it is reportedly held at head office in Wellington. The facility manager is supported by the assistant facility manager, whose position description is titled clinical services manager.</p> <p>The service is certified for 13 dementia care beds, 40 rest home beds and 169 dual purpose beds for rest home and hospital level care and 14 YPD; a total of 236 beds. It provides care and support under the local DHB Aged Related Residential Care Agreement (ARRC) for rest home, rest home dementia and hospital level care (geriatric and medical – non-acute), including for long term chronic health care conditions. There is a separate Ministry of Health (MoH) contract for young people with disabilities (YPD).</p> <p>At the time of audit, there were 10 residents receiving dementia care; two rest home and one hospital residents for long term chronic health conditions; three rest home and six hospital YPDs; 73 rest home residents and 44 hospital care residents, thus bringing the total to 139 residents. Two of these were receiving respite care support.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The facility manager advised that she is always a telephone call away no matter where she may be. Although it has not yet been required, if the facility manager is absent, the assistant facility manager is to carry out all the required duties under delegated authority. This person is a registered health professional, experienced in the sector and able to take responsibility for any clinical issues that may arise. A team of registered nurses is available for additional clinical support. The senior management team of HLL is accessible and can provide clinical and management expertise and support. They will visit the facility at short notice if the need arises. Staff reported they feel supported by the current management team.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk</p>	<p>FA</p>	<p>The organisation has a quality and risk system, which reflects the principles of continuous improvement. This includes management of incidents and complaints, internal and external audit activities, a regular patient satisfaction survey, monitoring of outcomes, review of clinical indicators, management of clinical incidents including infections, restraint management and staff education and training.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements and were</p>

<p>management system that reflects continuous quality improvement principles.</p>	<p>current. There are appropriate references to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Document control is managed at HLL support office by a quality manager and ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. All documents are updated and sent out via the facility manager. Staff informed they are frequently provided with copies of new policies and procedures to read and familiarise themselves with.</p> <p>Regular review and analysis of quality indicators and related information is reported and discussed at a series of meetings. Meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality related matters. These include meetings for housekeeping staff, the health and safety committee, care staff, registered nurses (for resident care reviews), and the quality team, which has representatives from all divisions. The minutes included discussion on pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results, corrective actions updates, quality improvement projects and activities. Data is reviewed to identify areas for improvement. Staff reported their involvement in quality and risk activities through meeting attendance, reading quality and staff meeting minutes, internal audits, health and safety activities and keeping senior staff informed of concerns. An annual internal audit schedule that sets out a comprehensive programme of audits across the year to monitor all aspects of the service is in place. Appropriate audit tools were available. Relevant corrective actions were developed and implemented as necessary.</p> <p>The managers informed of their commitment to improve the life and quality of care of residents. A process of quality improvement is occurring with one initiative being the implementation of a GP visit form, which according to the evaluation was successful and the wider organisation has now adopted its use nationwide. Other initiatives have included a registered nurse newsletter which was implemented to improve communication; significant efforts to review clinical files and archive unnecessary paperwork; a review of the roster to enable more consideration for staff lifestyles; and a project to reduce the number of residents' pressure injuries is in progress. Resident and family surveys are completed annually. The last resident survey showed one corrective action was identified and followed up. The staff survey was released in October with review of results due in November 2018.</p> <p>There is a standard HLL risk management plan which Cantabria Lifecare has added to in order to be site specific. The deputy facility manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies, as per the plan. The risk register showed updating of risks as identified. Health and safety is a component of the quality and risk management system. There is a job description for the health and safety officer and the health and safety committee meets monthly. The facility manager is aware of and attended training in the Health and Safety at Work Act (2015) requirements.</p>
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<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>Policy and procedures described essential notification reporting requirements for events such as a missing resident, pressure injuries, human resources shortfalls, infection outbreaks, the coroner and management changes. The assistant facility manager/clinical services manager is responsible for clinical indicators and sending section 31 documentation to HLL senior management team prior to it being sent to authorities. A register of such documentation that includes Ministry of Health responses was sighted and demonstrated relevant reporting and follow up actions are occurring.</p> <p>There is a document of guidelines for incident/accident management, which has information on the response to different types of events including falls, abuse, infections, damage to property/equipment, medicines, security and safety. Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans are developed, and actions are followed-up in a timely manner. Graphs of a range of incidents were viewed and reports of the analysis of related data was viewed. Such information is reported through the quality team meetings and filters through the department meetings.</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>PA Moderate</p>	<p>Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records are systematically maintained for staff who have been employed since the change of ownership to Heritage Lifecare Limited. Employment records were unavailable or incomplete for staff who were previously employed in this facility.</p> <p>There are a sufficient number of trained and competent registered nurses who are maintaining their annual competency requirements to be able to undertake interRAI assessments.</p> <p>A comprehensive staff orientation process includes all necessary components relevant to the person's role. Newer staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff informed during interview that the orientation is more successful if the new staff person commences work in the same part of the facility in which they did their orientation, but this does not always happen. The managers stated that they ensure the orientation is comprehensive to the entire facility, rather than just one area, and described how staff are suitably supported when they commence in their initial allocated area. Several models have been tried to ensure the needs of residents are met. Staff records reviewed showed documentation of completed orientation, all of which were satisfactory.</p> <p>There has been a review of staff education needs and a training schedule has been developed. At the time</p>

		<p>of audit there were a number of issues related to staff training that did not meet requirements, including the need for three-month appraisals of new staff, adequate activity coordinator review in the dementia service, training for all staff in the dementia unit and for staff to undertake the national caregiver certificate. These issues have been placed collectively into one corrective action.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	PA Low	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of residents. An afterhour on call roster between the facility manager and the assistant facility manager/clinical services manager is in place. Staff reported that good access to advice is available when needed, especially from the experienced registered nurses.</p> <p>The assistant facility manager informed that they have increased the number of casual staff employed to relieve when staff are on leave. Staff have also been consulted about their availability and willingness to increase their hours or do an additional shift. Care staff reported that earlier in the year they frequently worked short-staffed, but this has changed, and although there are still times when people may be rostered in an area they are not familiar with, there have been improvements and it has become easier to complete the work allocated to them. These positive changes were confirmed by family interviewed.</p> <p>Observations and review of a four-week roster cycle sample confirmed adequate staff cover is being provided. Staff with dementia training are being rostered in the dementia wing for morning and afternoon shifts when possible; although as noted for corrective action in criterion 1.2.7.5 there are insufficient dementia trained staff to cover all shifts every day. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24//7) registered nurse coverage in the hospital as well as in the rest home. As noted in 1.3.4, at the time of audit there were adequate numbers of registered nurses who have completed, or almost completed interRAI training; however, the service provider is still catching up on a backlog prior to the latest group completing the requirements.</p> <p>Details of staff allocations in the dementia wing and the hospital services during the night shift were unclear and this has been raised for corrective action.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current,</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are 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</p>

<p>confidential, and accessible when required.</p>		<p>information was on public display during the audit.</p> <p>Resident records were reviewed. The resident's name, date of birth and National Health Index Number (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical records were current and integrated with the medical and allied health service provider records. Records were legible with the name and the designation of the person making the entry identifiable.</p> <p>Archived records are held securely at the facility and are readily retrievable using a cataloguing system.</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>	<p>FA</p>	<p>All residents that enter the service have had their required level of care assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. For residents entering the dementia unit, EPOA documents and admissions agreements, EPOA consent and specialist referral were sighted. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the Needs Assessment and Service Coordination (NASC) service and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current</p>	<p>PA Low</p>	<p>The medication management policy was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are</p>

<p>legislative requirements and safe practice guidelines.</p>		<p>competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge reviewed were within the recommended range and evident in the hospital treatment room but temperature readings for the medication fridge in the rest home treatment room were not always documented.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The medication electronic device showed that for 11 residents their three-monthly GP review was not up to date. The 11 residents' files were reviewed, and evidence was sighted to show that the GP reviews were up to date and all the residents had been seen by the GP. Standing orders are not used.</p> <p>The facility supports all residents who are deemed competent to self-administer medications. There were three residents who were self-administering medications at the time of audit. Not all processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a kitchen manager, three trained chefs and kitchen team and is in line with recognised nutritional guidelines for older people. The four weekly menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Rotorua Lakes Council and expires on the 27 March 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, with the chefs and kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access</p>

		<p>to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys, resident meeting minutes and in a menu communication book located in the residents' dining room. 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>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. InterRAI assessments are completed by one of 15 trained interRAI registered nurses on site and include the rest home/dementia unit co-ordinator and assistant facility manager. There are currently four residents awaiting transfer of their interRAI assessments from the NASC. A further seven interRAI assessments are yet to be completed, at the time of audit the interRAI assessments were due between the 25 October 2018 and the 30 October 2018. The assistant facility manager interviewed stated that these assessments will be completed by six registered nurses whom are currently completing their interRAI training. All residents' files reviewed had up to date long term care plans. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed for all residents, both younger and older. Behaviour management plans including triggers and interventions for behaviours were sighted in residents residing in the dementia unit and this information was highlighted throughout the resident's activity plan.</p>

continuity of service delivery.		Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
<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	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. Two GPs and Nurse Practitioner (NP) interviewed, verified that overall, communication and care is improving. Medical input is sought in a timely manner and medical orders are followed. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
<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 an activities co-ordinator and three activities assistants and supports the residents Monday to Friday from 8.00 am to 5.00 pm. The residents in the dementia unit are specifically supported by an activities assistant Monday to Friday 9.00 am to 5.00 pm. The team is also supported by a regular volunteer. Currently the facility does not have access to a trained diversional therapist or similar professional for oversight of the activities programme in the dementia wing. Plans were put into place during the audit for this to occur through another local HLL facility which has a trained diversional therapist (see criterion 1.2.7.5).</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents under the age of 65 are encouraged to maintain links with the community and are supported to go out most days. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and day to day conversations with residents and visiting family members. Residents interviewed confirmed they find the programme interactive and lots of fun.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes one to one, distraction and reminiscence.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or 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. The service has a 'house doctor' who supports the majority of the residents with the remaining residents choosing to be supported by other medical practitioners and a nurse practitioner. If the need for other non-urgent services are indicated or requested, the GP, NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to 'plastics' and diabetes specialist teams and district nurse for wound support. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances were in place. Infection control documentation includes a waste management section detailing procedures for waste management and disposal. External contractors manage the various types of waste including general, infectious, recycling (cardboard), sharps and trade waste (grease traps).</p> <p>Hazardous substances are predominantly stored in the maintenance shed and appropriate signage is displayed. An external company is contracted to supply and manage all cleaning products and they also provide relevant training for staff. Material safety data sheets were available where cleaning chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment including plastic aprons, gloves and face shields. Staff were observed using these appropriately.</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>Cantabria Lifecare is a large facility comprised of two main buildings with multiple wings off each. Retirement village units are on the same grounds. One of the main buildings is referred to as the hospital and has five main wings. The other is referred to as the rest home and this has three main wings, two of which have an extension. The dementia service is downstairs in the rest home. Despite the fact that the unit felt oppressive to the auditor with windows predominantly along one side only and much of the garden area enclosed by a bank on one side and the building on the other, it has been in operation for a number of years. There have been no complaints about it reported and there was no evidence of any shortfalls in care. The facility manager and a manger from Heritage Lifecare assured the auditors that plans are underway to move the dementia service elsewhere. Plans and timeframes are yet to be determined, but the managers confirmed that change will occur. It was reported that a meeting regarding the move of the dementia unit was being held at support office during the audit. In the interim, the new provider has brightened the internal environment with artwork and fresh paint.</p> <p>A current building warrant of fitness that expires 9 October 2019 was on public display in both the hospital and the rest home buildings.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme. Buildings, plant and equipment are maintained to an adequate standard. Efficient systems are in place for monitoring the functioning and safety of equipment and the internal and external environments. All but two of the young people with disabilities are older, or over 65, and equipment and facilities are meeting their needs. Those spoken with are fully satisfied living within this large care facility.</p> <p>The testing and tagging of electrical equipment and calibration of bio medical equipment are current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Hot water temperatures are monitored monthly and were at safe levels.</p> <p>The internal and external environments are conducive to the range of activities undertaken in the areas, which includes a secure patio and garden environment for people in the dementia wing. A team of maintenance and garden workers ensure the environment is hazard free. Staff interviewed knew the processes they should follow if any repairs or maintenance was required. Fully completed maintenance records showed that any requests are appropriately actioned. Residents and family member informed that, although the external environment had deteriorated for a while, this has since been rectified and is no longer an issue.</p> <p>An on-site swimming pool is available for the use of rest home and hospital residents. The supervisor for the pool was interviewed and described the safety systems for managing the water and the environment as well as the safety requirements for individual residents. All information provided met required health and safety standards.</p>
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<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is a mix of toilet, showers and bathing facilities. This includes rooms with ensembles, a shared bathroom between rooms and communal bathrooms. A detailed record of these facilities in each of the wings was provided. There are adequate numbers of accessible bathrooms and toilets throughout the facility with the type of facility matching the type of resident in the different areas. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. One room is shared, and a married couple currently live in this room. Rooms are personalised with furnishings, photos and other personal items displayed. Staff reported that residents and family members, especially in the dementia service, are encouraged to bring in items personal to the resident.</p> <p>There are store rooms and alcoves to store mobility aids, walking frames and wheel chairs. Staff and residents reported the adequacy of bedrooms. Mobility scooters are stored in designated areas and do not impede walkways or create a hazard for mobile residents.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in both organised and individual activities. The dining and lounge areas are spacious and enable easy access for residents and staff, including those in wheelchairs and lazy boys. With a number of nooks and alcoves around the different wings, residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. It is arranged in a manner which enables residents to mobilise freely.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p> <p>Consumers are provided with safe and hygienic cleaning and</p>	PA Low	<p>Laundry, including personal items, is undertaken on site in dedicated laundries operated by Cantabria Lifecare staff. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry manager and the dedicated laundry team were interviewed and demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen.</p>

<p>laundry services appropriate to the setting in which the service is being provided.</p>		<p>Appropriate training on safety, the products in use, equipment and laundry systems is provided to staff and documented processes were sighted.</p> <p>There is one laundry in the hospital building and another downstairs in the rest home building. Modifications in progress to the downstairs laundry area are being appropriately managed to reduce the risk of infection and to ensure the safety of residents in the dementia service.</p> <p>There is a small designated cleaning team and all members have received appropriate training. Chemicals were stored in lockable cleaners' cupboards in each building and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and evidence of this having been completed was sighted.</p> <p>Sluice room areas and a store cupboard holding potentially hazardous cleaning substances were not always locked during the audit and a corrective action has been raised.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service 17 May 2018 when a full review of evacuation procedures was undertaken. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 6 July 2018. The orientation programme includes fire and security training and it is a topic for ongoing mandatory training. Staff confirmed their awareness of the emergency procedures, although as noted in 1.2.7, it is difficult to ascertain who has/has not received updated training with numbers attending sessions being low. Managers informed they are about to roll out new emergency training in December, in time for the next evacuation due January 2019.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for full occupancy. Water storage tanks are located around the complex, and there are two generators on site. One resident has emergency care requirements, which is well documented, and staff were aware of the person's needs in the event of an emergency. Specific mention of emergency management in the dementia service is noted. The young people with disabilities reside in the relevant rest home or hospital care areas and follow the same procedures. Emergency lighting is regularly tested when the contractor completes other fire compliance checks.</p> <p>Call bells alert staff to residents requiring assistance. A new nurse call system has been rolled out in the hospital wing and installation of the new system has commenced in the rest home area. Residents and families reported there were some previous problems with slow responses to call bells but these have since resolved as staff now respond promptly to call bells.</p>

		Appropriate security arrangements are in place. Doors and windows are locked automatically at a predetermined time, in-house checks are completed at night and a security company checks the premises twice each night. Residents who go out, especially some of the young people with disabilities who go out more frequently, are required to sign out of the building.
Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas have opening external windows. Ventilation fans are in bathrooms and ensuites. Geothermal electric wall mounted radiators provide the main heating source in all areas throughout both buildings. A private company monitors the system and any significant deviation in temperature sends an alert to a monitoring device which a person will respond to at any time of the day or night. Electric oil heaters are available if residents are cold. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual. The infection prevention and control programme is reviewed by Heritage Lifecare quality team annually. The infection control programme includes all aspects of the infection control system and the functions of the committee.  The infection control coordinator (ICC) is a registered nurse who has only been in this role since August 2018. The ICC reports to the unit coordinator who in turn reports to the facility manager monthly. The ICC has a job description which defines the role and responsibilities.  The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.
Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme	FA	The ICC interviewed was orientated to the role and has the appropriate skills, knowledge and qualifications for the role. The ICC previously working in accident and emergency and pursued a similar role and has completed relevant training. Networks are established with the infection control team at the local DHB who are available to give advice on any situations that arise. The GP's and other health professionals can also provide appropriate information as required.  The ICC has access to residents' records and diagnostic records to ensure timely treatment and resolution of any infections. The ICC and the committee, including one caregiver, the clinical manager, a cleaner and

<p>and meet the needs of the organisation.</p>		<p>the kitchen manager, meet monthly and minutes of meetings were accessible.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of infection. The service had an infection outbreak (influenza) - 8 September 2018 - which was contained effectively within one week. All strategies were put in place to alleviate the spread of infection. The GPs were notified and public health with daily updates being provided. Staff were given time to rest and recover.</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 good practice. The policies and procedures are available on-line for staff to access. Resource material on infection prevention and control is in the nurses' offices in each of the wings.</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 as appropriate to the setting. Hand washing and sanitisers were in use around the facility. Staff interviewed verified knowledge of infection prevention and control policies and procedures.</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>Infection prevention and control and standard precautions are included in the education programme for all staff. Staff receive training at orientation/induction and this is ongoing. A record of attendance is maintained. Education can also be accessed through Lakes District Health Board (LDHB) and the service is looking at accessing education from Waikato DHB. Ministry of Health on-line training is also accessible for staff and staff are completing this currently.</p> <p>When an infection outbreak or an increase in infection incidents has occurred, there is evidence of additional staff education provided in response to this. An example of this occurred with the influenza outbreak in September 2018.</p> <p>Education with residents is generally provided on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies/skin infections. When an infection is identified, a record of this and management is documented in the residents' clinical records and on an infection reporting form. New infections and any required management plans are discussed at handover, to ensure that intervention occurs. Information is provided to the unit coordinators and the infection control report is documented from the statistics available. The rest home infection control statistics, hospital statistics and the individual wings statistics are reported on and interpretation is clearly documented. Three months of records were reviewed. Graphs and incidences of infection were easy to follow. Monthly comparisons were made for quality improvement purposes. Results are reported to the quality, staff and management meetings.</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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her roles and responsibilities.</p> <p>On the day of audit, eight residents were using restraints (one resident is supported with three different forms of restraints), and three residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
<p>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</p>	<p>FA</p>	<p>The restraint approval group, made up of the assistant facility manager, rest home/dementia and hospital unit co-ordinators and restraint co-ordinator with support from the GP, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making process was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>

and others.		
<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 the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The RN interviewed/restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example, the use of sensor mats and low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours with further training for staff booked for December 2018. 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, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use and trending of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit, last completed November 2018, also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>Continuing education is planned for the current year. Mandatory training requirements including for residents’ rights, restraint, infection control and emergency management are defined and scheduled to occur over the course of the year. More than 50% of the staff have not met their mandatory staff training requirements as there were no internal training opportunities offered for a period of time; some training sessions have been cancelled and there has been poor attendance at those offered with an average of four to six staff attending the sessions provided.</p> <p>It was reported that a limited number of caregivers completed or commenced a New Zealand Qualification Authority education programme; however, there are gaps in information available as to who had completed what level. Heritage Lifecare Limited promote caregivers undertake training for a relevant certificate; however, none of the caregivers have attended such training in 2018 and at the time of audit, none had been enrolled for 2019. The clinical services manager informed a strategy is in place to remedy this in 2019. The need for staff in the dementia service to complete dementia care specific training was identified</p>	<p>A training schedule is in place and training opportunities are being made available to staff.</p> <ul style="list-style-type: none"> <li>- Records demonstrated that not all staff have completed the mandatory training topics.</li> <li>- There was limited evidence of caregivers participating in</li> </ul>	<p>The system that facilitates ongoing education of service providers shall ensure staff complete mandatory training topics and contractual requirements are met for the ongoing training of caregivers and dementia</p>

		<p>during an internal audit and a corrective action plan required staff to commence their dementia unit standards, or be removed from the dementia unit. Some part day and one day dementia training opportunities have been made available; however, records provided do not demonstrate that all staff working in the dementia care area have yet completed, or are enrolled in such education, at the required level. The actual number was difficult to ascertain as there have been significant staff changes in the unit and the records do not clearly co-relate between attendees at dementia training, and the frequency of the person working in the dementia unit.</p> <p>Staff annual appraisals are being completed according to a schedule; however there was no evidence to demonstrate that any of the new staff employed since February have undergone a three-month appraisal following employment, as per Heritage Lifecare Limited policy and procedures. As noted in 1.3.7, at the time of audit the activity coordinators in the dementia service do not have the level of supervision as required by the contract with the DHB, although plans were made during the audit for this to occur in the future.</p>	<p>qualifications, such as the national certificate.</p> <ul style="list-style-type: none"> <li>- The staff training recording system could not consistently demonstrate that relevant unit standards on dementia care have been completed by all staff working in the dementia service.</li> <li>- Activity coordinators do not currently have access to a qualified diversional therapist, or similar professional for guidance and review of their work within the dementia service.</li> <li>- A three-month post-employment appraisal is not occurring for new staff.</li> </ul>	<p>services workers.</p> <p>Evidence is required that activity coordinators in the dementia service have access to a relevant qualified professional who can oversee the assessment, goal planning and evaluation of activities for dementia care residents.</p> <p>New staff require a three-month appraisal, as per good employment practice and Heritage Lifecare policy.</p> <p>90 days</p>
Criterion 1.2.8.1	PA Low	Two weekly rosters are operating with a standard pattern evident. All shifts are	A comprehensive	The roster, or

<p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>		<p>being covered with safe staffing numbers and a registered nurse is available in both the rest home and hospital buildings on each shift. Although staff names were allocated to rest home and hospital areas for the night shift, the roster does not specifically state who will cover each wing of the hospital, or who will cover the dementia service. It is therefore unclear who is expected to oversee each of the hospital wings, or the dementia service. The assistant facility manager/clinical services manager described how the team would work it out among themselves and this was confirmed by a registered nurse who sometimes does night shift. There were no guidelines available to assist with these decisions and nor is any person allocated to make these decisions each night. There was a lack of evidence that service providers with appropriate skills and experience are covering all areas of the facility during the night shift.</p>	<p>two weekly roster is in place. It is unclear on this roster who covers the night shift in the dementia service, or who covers the different wings within the hospital facility, and there is no documented framework or guidelines as to how these various areas shall be covered by suitably qualified and experienced staff.</p>	<p>associated documentation, clearly demonstrates how the hospital and dementia care areas will be staffed by suitably qualified and experienced staff during the night shift.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation,</p>	<p>PA Low</p>	<p>The staff interviewed could recall the proper procedures required when storing medications in a fridge. There was evidence of regular monitoring and recording of temperatures for the medication fridge in the hospital. The medication fridge in the rest home had no documented temperatures recorded since the 19 September 2018. Between the 1 September and the 19 September 2018 there were 11 days where recordings were not documented.</p>	<p>Not all fridges storing medication had regular temperatures monitored and recorded.</p>	<p>Provide evidence that all fridges that store medication have temperatures monitored.</p> <p>7 days</p>

protocols, and guidelines.				
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	<p>One resident is self-administering a controlled drug. The resident has an up to date competency supporting self-administration of medication. On the day of audit the medication was observed to be stored securely in the residents' bedroom. The controlled drug (liquid form in a 100ml bottle) is documented as given to the resident in the controlled drug book and electronic medication device; however there is no documentation to show evidence of when the resident is actually taking the controlled drug.</p>	<p>Staff are not monitoring and recording a controlled drug that a resident is self-administering.</p>	<p>Provide evidence that all residents who are self-administering a controlled drug have this information recorded when the controlled drug is been taken.</p> <p>7 days</p>
<p>Criterion 1.4.6.3</p> <p>Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	PA Low	<p>Four different cupboards/sluice rooms and a store room holding hazardous substances (and one holding confidential information) were found unlocked on day one of the audit. A lock was replaced overnight to improve the security of confidential information in a rest home wing. Despite reminders provided, a room containing potentially hazardous cleaning products was still found unlocked on day two of the audit.</p>	<p>Cupboards containing potentially hazardous products are not always being locked as required to ensure residents' safety.</p>	<p>Cleaning chemicals, including those used by care staff, are held in safe storage areas, at all times.</p> <p>30 days</p>

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

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

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

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

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End of the report.