

Heritage Lifecare Limited - Pururi Court Rest Home and Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Pururi Court Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 January 2019 End date: 30 January 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	64

Executive summary of the audit

Introduction

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

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

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

Puriri Court Rest Home and Hospital, Whangarei, provides rest home and hospital level care for up to 74 residents. The service is operated by Heritage Lifecare Limited (HLL) and is managed by a facility manager and a clinical services manager. Changes since the last audit relate to a new clinical services manager, changes to the clinical structure to include a unit coordinator and the introduction of an electronic reporting system. Residents and families spoke positively about the care provided.

The audit was conducted against the Health and Disability Services Standards and the service's contract with the DHB. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a general practitioner. This audit included follow up on issues raised by complaints to the district health board (DHB) and Health and Disability Commissioner (HDC).

This audit identified areas requiring improvement related to documentation of service delivery and staff training. Improvements have been made to communication, clinical governance and environmental issues raised in the complaints reviewed.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is a policy on open disclosure and evidence of this occurring was sighted. Open communication between staff, residents and families is promoted, communication was confirmed as being improved since complaints were lodged related to this area. There is access to interpreting services if required.

The organisation has system in place to promote feedback from residents and family members and investigate and plan corrective actions in relation to complaints. A complaints register is maintained with complaints being investigated and resolution sought promptly and 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 low risk.
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Heritage Lifecare Limited undertakes strategic planning which is used to guide facility specific business and quality and risk management plans. These contain the vision, core values and goals. Reporting by the facility manager and clinical services manager to Heritage Lifecare Limited occurs weekly and monthly.

The suitably qualified manager is supported by a clinical services manager and unit coordinator. The clinical services manager and unit coordinator are registered nurses.

The quality and risk management system includes the collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. A suite of policies and procedures cover the necessary areas, were current, reviewed regularly and as needed.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. An orientation and an annual staff training programme are in place. Annual appraisals are undertaken.

Staffing levels and skill mix meet contractual requirements and the needs of residents. Senior staff are on call after hours and at weekends.

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 medium or high risk and/or unattained and of low risk.
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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that safely meet the needs of the residents and contractual requirements.

Residents have interRAI assessments completed and care plans are then developed. Short-term plans are developed, for example, for infections and wound management. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a seasonal rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness which is displayed at the entrance to the building. No major building changes have occurred since the last audit.

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. Four residents were identified as using enablers and four using restraints at the time of audit. Staff demonstrated a 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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Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

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	14	0	1	1	0	0
Criteria	0	37	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy meets the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission. A suggestion box and compliments/complaints and suggestions forms are available at reception. Residents and family members described who they would go to if they had an issue. They were highly complementary of the services they or their family member were receiving. Staff spoke of identifying issues and dealing with them at the lowest possible level where they could or referring onto the facility manager or clinical services manager (CSM).</p> <p>The organisation records compliments (62 in 2018) and has a complaints register. The facility manager is responsible for complaints management and follow up. Review of complaints showed that 13 complaints have been received in 2018, eight DHB complaints were received between 2017 and 2018 and two HDC complaints. Of these, all DHB complaints are now closed and the organisation has provided information to the HDC and is awaiting the HDC outcome. The complaints register, plus detailed files on the investigations showed relevant timeframes being met. Action plans showed any required follow up and improvements have been made where possible. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>Included in the audit, issues identified in the DHB and HDC complaints were followed up. The issues related to:</p> <p>The lack of effective facility leadership, a lack of effective clinical governance and supervision of the direct care staff.</p>

		<p>Timely initiation and coordination of the required care and support interventions, (e.g. up to date care plans which also include information such as recent discharge letters and other prescribed treatments).</p> <p>The provision of timely information and effective communication with the resident and their families regarding care, evidenced timely follow up following discussions with residents/families.</p> <p>Environment: - quality of bedrooms, and safety of external environment.</p> <p>Food service – ensuring special food and nutrition requirements are available to meet resident’s needs.</p> <p>The organisation have undertaken corrective action in relation to the areas of concern and this has been effective in most areas. Areas identified that require improvement relate to timely initiation and coordination of the required care and support interventions, refer criteria 1.3.3.4. Areas of training were suggested in the recommendations of some of the complaints and evidence related to these are reported in criteria 1.2.7.5.</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>A lack of timely and effective communication with relatives was raised in complaints to the DHB and HDC by family members. The facility manager spoke of changes in staffing which she stated has seen a difference in approach to family members with positive effects. She also stated and provided evidence of family meetings being organised on an ongoing basis to discuss issues raised. Discussions with staff on communication occurred during staff meetings to raise an awareness of good communication. Residents and family members spoken with were complimentary of the communication between them and staff. They stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed.</p> <p>The facility manager described and understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code and evidence of application was reviewed in one incident.</p> <p>The organisation has an interpreter services policy and brochures for interpreter services were available at the entrance to the facility. The facility manager stated that all residents spoke English and if she had a need for an interpreter, she would contact the DHB. Two family members spoke of their relatives having English as a second language, but that they have spoken English for many years and no interpreting services were required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of</p>	FA	<p>HLL have a strategic plan which forms the basis for the facility specific business plan. The facility manager provided a copy of the business plan for 2018-2019, which was signed off by the HLL operations manager. There is a vision, core values and goals and quality objectives set out in the quality and risk plan and in other documents. The facility manager and interim facility manager, who was visiting and giving support to the facility</p>

<p>the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>manager, stated these are reviewed annually at the HLL conference attended by senior management. A sample of weekly and monthly reports to the HLL national office showed adequate information to monitor performance is reported including financial performance, staffing, clinical indicators and emerging risks and issues.</p> <p>The facility has a manager who has a background in a range of areas including administration, with a certificate in small business and a care of the elderly certificate. She has experience in the aged care setting for over ten years within various roles and stated she commenced her present position in 2014 having worked in the facility in another role. The position description outlines the various delegated authorities and responsibilities held by the manager.</p> <p>The manager is supported by the CSM and unit coordinator who are registered nurses, who hold relevant clinical roles and provide reports on clinical indicators.</p> <p>The service holds contracts with the DHB and MoH for young persons with physical disability (YPD), respite care, rest home and hospital level care. Sixty four residents were receiving services under these contracts, with four under the YPD contract, one respite resident, twenty six rest home and thirty three hospital at the time of audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The 2018-20 quality and risk plan reflects the principles of continuous improvement. This is overseen by the facility manager and a quality committee who meet monthly. Monthly reporting to the HLL national quality and compliance manager occurs related to quality and clinical indicators; incidents and complaints, annual audit activities, family and general practitioner satisfaction survey, monitoring of outcomes, clinical incidents (including infections, pressure injuries, falls, skin tears), and quality projects. The CSM stated, targets are set for these indicators and benchmarking with other HLL facilities occurs. Residents' meetings occur, led by the activities staff and are attended in part by the facility manager.</p> <p>Quality meeting minutes reviewed identified all the expected elements of quality and risk are discussed, and where appropriate, corrective actions are undertaken and reported on at the next meeting until resolved. Staff meeting minutes showed quality and risk being discussed and actions reported. Minutes and reports are also available to staff in the staff room. Residents' survey results showed a high degree of satisfaction with the services being provided. Issues identified at these meetings are addressed and reported at the next meeting.</p> <p>HLL policies are available to staff via the intranet and hard copy manuals. The manager spoke of how these are developed with input from the facility and signed off by the national office. Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, approval, and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Review of the risk and hazard registers confirmed the process and the</p>

		<p>facility manager gave an example of updating the hazard register, from a DHB complaints issue. The managers were able to provide evidence of training on the Health and Safety at Work Act (2015) and implementation being undertaken where requirements. There is a health and safety committee with appropriate staff members and the minutes reviewed showed hazards being identified and managed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events via the 'eCase' (electronic) system. Most staff find reporting on the system easy to use, but a form can be used if preferred and the RN or CSM will then enter the event on the electronic system. The CSM described how key words alert senior staff to specific incidents for investigation. The eCase system does not allow for detailed reporting, this is done in the patient's clinical notes. A sample of the 20 reports lodged on the system this year, showed these were fully completed, sufficient detail being recorded in the clinical notes, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the quality committee and national quality and compliance team.</p> <p>The CSM described essential notification reporting requirements, including for pressure injuries. They advised there have been reporting of significant events made to the Ministry of Health, since the previous audit.</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>	PA Low	<p>HLL human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Two recently employed staff files were reviewed and showed not all documentation was present; however, this was amended during the audit. A file is kept of all health professionals (nurses, podiatrist, general practitioner, dietitians and pharmacists) current APCs. A further sample of staff records reviewed confirmed the organisation's human resource policies are being implemented and records are maintained.</p> <p>Staff orientation includes a workbook and working under supervision of a senior staff member. The orientation contains all necessary components relevant to the role. Staff reported that the orientation process is undertaken, but some stated they still did not feel prepared for their role. In discussion with the manager, the three monthly performance review is used to identify any staff concerns and in one file reviewed no concerns were raised by the staff member. The facility manager is to follow this up with staff. Staff records reviewed showed documentation of completed orientation and a performance review after three-months.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Documented evidence that all staff have completed this training for 2018 was not available. Health care assistants have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements</p>

		of the provider's agreement with the DHB. The facility manger has been the internal assessor for these programmes. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of annual performance appraisals.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>HLL have a national policy, process and template used to determine staffing levels and skill mixes to provide safe service delivery, based on current guidelines. This covers 24 hours a day, seven days a week (24/7). Rosters are completed two weeks in advance. The CSM is responsible for the rostering of staff and described how staff are on a fixed roster but can request changes. He spoke of how the facility adjusts staffing levels to meet the changing needs of residents and there is a 'floating' HCA on the morning to provide additional support. There are two RNs on duty in the morning and afternoon shifts as well as the CSM and unit coordinator Monday to Friday morning, who also provide supervision and additional support to staff. One RN is on night duty. It was observed and staff spoke of having sufficient time to carry out the cares requirements.</p> <p>An afterhours on call roster is in place, which includes three senior RNs CSM, clinical coordinator and GP liaison RN). The CSM and facility manager spoke of how they ensure supervision of junior RNs and support RNs after hours and at weekends by rostering senior RNs on call. Staff reported that good access to advice is available when needed. Health care assistance (HCAs) reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Review of four-week of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is 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 including the infection control processes required during medication management, for example, the use of hand gel between residents, use of gloves when administering eye drops to residents and the cleaning of spacers (to support inhalers) each evening by the night staff. All staff who administer medicines are 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</p>

		<p>administering. The controlled drug register provided evidence of weekly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used as the GP is available and has access to the medication electronic system as required.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner, when required.</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 qualified chef, weekend cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The kitchen roster ensures that the chef or cook is on site from 7.00 am to 5.30 pm with support of a kitchen assistant from 7.30 am to 1.45 pm and in the evening from 4.00 pm through to 7.45 pm. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years.</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 Whangarei District council which expires 31 July 2019. The service completed a verification audit with an excellence (A grading) which expires on the 28 February 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan.</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 for residents are made known to kitchen and care staff both verbally and with the support of an initial and updated nutritional profile, when necessary. Long term care plans and supporting documents, such as an updated nutritional food profile and food/ fluid plans, were sighted in two residents' files reviewed who have issues with swallowing and/or required a change in diet and/or support with eating their meals. At the time of audit there were three residents requiring a soft diet and eight residents requiring a moulied diet. Evidence of residents requiring support from a dietician and/or speech language therapist were also sighted. The chef, cook and kitchen staff have not completed recent training in food handling training and modified diets (see criterion 1.2.7).</p> <p>All meals are cooked on site and served by the chef and/or cook to residents in the hospital dining room and two further dining rooms with the support of 'hot boxes'. Residents also have the option of having meals in their bedrooms.</p>

		Evidence of residents' satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care; however, the care that the residents received was not always reflected in the care plans (see criterion 1.3.3.4). The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care provided is well managed. A range of equipment and resources including allied health support was available, suited to the levels of care provided and in accordance with the residents' needs. Care staff interviewed knew the residents well.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	<p>The activities programme is provided by two activities co-ordinators who are both currently training to become diversional therapists. The activity team support the residents Monday to Friday from 8.30 am to 4.30 pm.</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 as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, day to day discussions and satisfaction surveys.</p> <p>Each resident is provided with an activities calendar in their room and information is also highlighted on the main notice boards throughout the facility. The activities team visit each resident every morning and remind the residents what is occurring for the day. For residents that choose not to partake in activities, one to one discussions and activities occur that are of interest to the resident. The activities team interviewed stated that if they were concerned about a resident a discussion was had with the registered nurse and documented in the progress notes.</p> <p>Residents interviewed confirmed they find the programme interactive and of interest, in particular, the regular van trips in the community, the daily walking group, the facility's mobile ice cream cart and visits to the library where the residents interact and read to the children.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' 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. InterRAI assessments were up to date for all residents but did not always reflect the resident's current level of care (see criterion 1.3.3.4). Where progress is different from expected, the service does not always respond 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. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>	FA	<p>The current building warrant of fitness expires in December 2019. The appropriate monitoring in relation to the certificate is being undertaken. No changes to the building have occurred since the last audit.</p> <p>The maintenance person confirmed that ongoing and proactive maintenance is undertaken. All equipment sighted had current test and tagging occurring. External painting is scheduled for this year. Environmental surveillance during audit identified that all areas visited were fit for purpose.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. All infections are reported and documented by the registered nurse/unit coordinator whom commenced the role of infection control co-ordinator in December of 2018 and is supported by the clinical services manager. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Thirty-three (33) residents and 26 staff consented to the flu vaccine in May 2018.</p> <p>The facility has had a total of 71 infections from July 2018 through to and including December 2018. Four (4) residents have been identified with eight of those 71 infections due to co-morbidities. One resident has since deceased, the remaining three residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection; however, not all short-term care plans showed appropriate interventions, other than to 'complete the course of antibiotics' (see criterion 1.3.3.4).</p> <p>Corrective action plans were actioned in December 2018 due to the increase in urinary tract infections from three</p>

		<p>to nine and chest infections from five to six. Interventions included an increase in fluid rounds and a discussion with all staff re infection control. Further training was provided covering indwelling catheters and physical assessments of residents. The facility has been in contact with the infection control team at the DHB to support ongoing further training for staff. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and interventions. Data is benchmarked internally within the group monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>The clinical services manager interviewed stated that the facility has not had an infectious outbreak in the last 12 months.</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>HLL policy 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 CSM is the restraint coordinator and he 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 his role and responsibilities. There is a committee who have been meeting annually to discuss restraint and enabler use.</p> <p>On the day of audit, four residents were using restraints and four 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. Two residents' files with enabler use were reviewed and showed monitoring of use of bed rails when in use.</p> <p>Staff interviewed are aware of the difference between an enabler and a restraint and this is part of the orientation and ongoing training.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective</p>	PA Low	<p>There is evidence provided by the facility manager, CSM and interim facility manager, that HHL provide a range of training to meet the needs of the standard and contract requirements. This includes online training modules, toolbox talks, a competency workbook, external speakers and opportunities to attend training outside the organisation. These are identified on the 2018 and 2019 training plans, which were reviewed. The main record of staff attendance at training for 2018 was incomplete for required areas. The CSM also keeps records of attendance at the training and some records are kept in the staff member’s personnel files. The recording list also contained staff who had left; these staff were discounted from the numbers where identified. The list does not state staff employed within the last three months, who will have undertaken some of the training as part of orientation.</p> <p>Shortfalls identified included:</p>	<p>There is an annual training plan which meets core and contract requirements. However, it was identified, that not all staff had completed this training in 2018. This included, infection prevention and control, manual handling and attending fire training. Not all RNs had a current first aid certificate available.</p> <p>Training recommendations were identified through the DHB complaints review last year; however, evidence of this training</p>	<p>A current record be kept of all staff training being undertaken. All staff undertake the required core and contract required training within the specified</p>

services to consumers.		<ul style="list-style-type: none"> - Eight out of twelve RNs had evidence of current first aid certification. This was noted, and RNs were to provide evidence of completion prior to coming on their next rostered duty. - Recording of RN's current InterRAI competency was not entered on the list - some were sighted in the staff files reviewed. - Wound care management - four out of twelve RNs have documented evidence of completion of wound care management. This was an area recommended by a DHB complaint. The CNM stated RNs were advised to complete the online training last year. - Manual handling - 19 out of 58 (HCA, RNs and activities coordinators) are not recorded as having undertaken this training in 2018. A training session for staff identified as not attending in 2018 occurred on the second day of audit. - Attendance at fire and safety drills - 20 out of 67 staff named on the record had not attended a fire drill in 2018. - Infection prevention and control - 44 out of 67 staff named on the record had not attended infection control training in 2018. A training session for staff identified as not attending in 2018 occurred on the second day of audit. <p>Areas for training were identified in the recommendations from the DHB complaints review. These were:</p> <ul style="list-style-type: none"> - HCA staff on the use of a new wet/dry vacuum cleaner for spills. No record of training was available at audit and HCAs could not state having had training. - Training of kitchen and HCAs on the different types of modified diets. Posters have been placed in the dining areas and the kitchen, but no training related to this was able to be found during the audit. - RNs have training on assertiveness and communication skills; no record of this was available during the audit. 	being completed could not be seen during audit. For example, kitchen and health care assistants have not had training on different types of modified diets, RN training on assertiveness and communication has not been completed and there was no evidence of training of the use of the new wet/dry vacuum.	time frames. 180 days
Criterion 1.3.3.4	PA Moderate	All residents on the day of audit have an up to date interRAI assessment, long and short-term care plans. Staff interviewed stated that they knew	Not all residents' interRAI, long term care plans and/or short-term	Provide evidence

<p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>		<p>the residents very well and were able to identify and meet their needs. Residents and family members interviewed stated that they were very happy with the care provided. The number of residents' files reviewed on the day of audit was extended from five to nine.</p> <p>One resident had a current interRAI assessment that stated the resident requires two people to assist with use of a transfer belt. This information had not been updated from the previous interRAI assessment as the resident now required the support of two people to assist with a hoist for all mobility transfers. It was also noted that the resident had required the support of a hoist for four years. At the time of audit, the same resident was observed on more than one occasion to be lying flat in their bed. Due to the ongoing support of a nutritional supplement the resident required 30-minute checks to ensure that the resident was positioned appropriately at all times. The electronic chart was updated at 30-minute intervals but there was no evidence documented to show what intervention and/or support was provided.</p> <p>Staff were able to show evidence of an outcome for a resident who had been seen by a podiatrist and GP and referred to a specialist in a timely manner due to ongoing foot management requirements related to ulcers as a result of co-morbidities. Staff interviewed were aware of and had implemented the interventions recommended by the specialist, with evidence of this recorded in the progress notes. A short-term care plan created prior to the out-patients' clinic also showed interventions. Information had not been updated in the long-term care plan.</p> <p>A resident's electronic drug chart showed a prescription for the use of an oxygen concentrator pro re nata (PRN – as required) dated 20 October 2018. Information was recorded in the electronic device's comments section and resident's progress notes supporting the reason why and the expected outcome of the use of the equipment. This information had not been updated in the long-term care plan.</p> <p>Due to a resident becoming acutely unwell, staff referred the resident to the public hospital on the 28 December 2018 having spoken to the GP and notifying the family. The resident was discharged back to the facility the following day having commenced antibiotics. The discharge summary was reviewed on the electronic database. Progress notes documented a discussion with the GP and review of medications. On return to the facility a short-term care plan was not completed to show</p>	<p>care plans reflected changes and current needs of the resident. Not all residents charting showed the intervention that was provided at the time.</p>	<p>that all residents' interRAI assessments and care plans reflect changes and provide interventions that identify and meet the current needs of the resident.</p> <p>90 days</p>
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		<p>that the resident had been commenced on antibiotics and that there were changes to medications to support ongoing pain management.</p> <p>A further three residents' files reviewed showed short term care plans in place for infections, but the only intervention documented was for the resident to complete the course of antibiotics.</p>		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.