

Heritage Lifecare (BPA) Limited - Riverside Care Home and Hospital

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:

Legal entity:	Heritage Lifecare (BPA) Limited
Premises audited:	Riverside Care Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 17 January 2019 End date: 18 January 2019
Proposed changes to current services (if any):	Reconfiguration to support residential, disability/physical certification.
Total beds occupied across all premises included in the audit on the first day of the audit:	63



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
	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
	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

Riverside care home and hospital provides rest home, hospital and dementia care services for up to 65 residents. The service is operated by Heritage Lifecare (BPA) Limited and managed by a facility manager and clinical services manager. Residents and families spoke positively 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. A reconfiguration to support the service provider application for a residential, disability/physical certification was also completed during this audit. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, the quality/education assessor, family members, managers, staff, contracted health providers and a general practitioner.

There were no areas identified as requiring improvement as a result of this audit.

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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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

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

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

A complaints register is maintained with complaints resolved 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.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the goals and values of the organisation. Monitoring of the services, provided to the national support office, is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes 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. Organisation wide policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on good practice. A comprehensive orientation programme is implemented for all staff groups. A systematic approach to identify and deliver ongoing education supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents. Registered nurse cover is provided 24 hours a day seven days a week.

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

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.		Standards applicable to this service fully attained.
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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 and general 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.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. 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.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

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

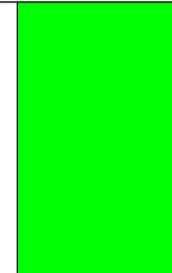
Restraint minimisation and safe practice

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 reviewed and recently implemented new policies and procedures that support the minimisation of restraint. One enabler and one restraint 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 process.

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.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The organisation has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy of both young and older residents. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Residents' files reviewed of those admitted to the dementia unit showed that the resident's enduring power of attorney had been enacted. Staff were observed to gain consent for day to day care.

consent.		
<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. Posters and brochures related to the Advocacy Service and contact details were also displayed and available at reception and throughout 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>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>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p> <p>A review of the requirements around the provider's application for reconfiguration/certification of the service to cater for residential services - disability/physical was completed and demonstrated that no changes will be required to the current service to cater for the needs of this group.</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>There is a complaints and concerns policy which meets the requirements of Right 10 of the Code. There is a flowchart associated with the policy to assist staff in understanding the process for complaints management. The information is provided to residents and their families on admission and there is information and forms available in the information pack and forms were sighted in all service areas of the facility</p> <p>The complaints register reviewed showed that four complaints have been received over the past year and that actions were taken through to an agreed resolution. Appropriate timeframes specified in the Code were effectively met. Action plans reviewed showed any required follow-up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The facility manager reported that there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, the District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or the Police since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report 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. The Code is displayed in the main foyer areas together with information on advocacy services, how to make a complaint and feedback forms.</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, younger and older, and their families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending regular community activities, arranging their own visits to the doctor, participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p> <p>A review of the requirements around the provider's application for reconfiguration/certification of the service to cater for residential services - disability/physical was completed and showed that young people with disabilities are able to maintain their individual identities and preferences.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The clinical services manager interviewed reported that there are three residents who affiliate with their Māori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is a specific current Māori health plan with all values and beliefs acknowledged with the support of the Te Whare Tapa Wha model and evidenced and integrated into long-term care plans with input from cultural advisers (local Māori minister and iwi) within the local community as required (see also criterion 1.3.7). Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. The residents whom affiliate with their Māori culture and their whānau were not available for interview.</p>
<p>Standard 1.1.6: Recognition And Respect</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</p>

<p>Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed 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, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, dietician, speech language therapist, wound care specialist, psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included knocking on residents' doors before entering, day to day conversations between residents, family and staff, and the acknowledging and welcoming of families visiting.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>FA</p>	<p>Both young and older residents and family members interviewed 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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. There were two residents acknowledged with a significant sensory impairment. There was appropriate equipment and resources sighted and highlighted in residents' long-term care plans reviewed, for example staff providing clear conversation and staff allowing time for the resident to respond. Support from external services included a speech language therapist.</p> <p>Language and communication needs for young people with a disability are able to be met with staff aware of individual requirements.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business plan 2018-2019, which is reviewed annually for the organisation, outlines the purpose, values, scope, direction and objectives of the organisation. The facility manager, clinical services manager and the quality manager at Riverside care home and hospital also develop site specific objectives which link with the quality plan objectives. The documents reviewed described annual and longer term objectives and the associated action plan. The facility manager provides weekly reports on occupancy, health and safety, complaints and compliance issues (incidents/accidents), new risks identified and/or any outstanding issues, for example. The quality manager interviewed provides monthly reports to Heritage Lifecare (BPA) Limited (HLL) directly to the general manager clinical and quality (GMCQ), including all clinical indicators and information provided from the clinical services manager. The information provided includes falls with and without injury, pressure injuries, infection rates and the narrative reports and data reports. The service quality manager collates the information and provides all information in graph form prior to forwarding onto the GMCQ. Prior to reporting to the GMCQ the quality manager reports the results to the facility manager, clinical services manager and the staff directly. If any trends are identified at this stage a corrective action form is completed and actioned as soon as possible.</p> <p>The service philosophy is in an understandable form and is available to residents and family/representatives or other services involved in referring residents to the service. It is also documented in the information pack provided and reviewed.</p> <p>The service is managed by a facility manager who is a registered nurse and has worked at this facility for nine years. They have been in the current manager role for two years. The facility manager is supported by the quality manager and a clinical services manager and has attended relevant business management and aged related conferences and study days.</p> <p>The service holds contracts with the district health board (DHB) and (MoH) for hospital, rest home, younger person disabled (YPD) dementia and respite care services. Sixty five (65) beds are available. On the day of audit, there were 63 residents; (21) rest home, (17) hospital level care, (6) YPD (MoH) (4) residents are (rest home level) and (2) are (hospital level). In addition there are (3) respite care residents (2) under ACC & (1) is rest home level care. There are (16) dementia level care residents.</p>

		A review of the requirements around the provider's application for reconfiguration/certification of the service to cater for residential services - disability/physical was completed. The provider is suitable to provide this service. No changes will be required to the current service. The organisation has been catering for the needs of this group for some time.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	When the facility manager is absent, the clinical services manager carries out all the required duties under delegated authority. The clinical services manager (CSM) has been in this role for two years. Support is also provided from HLL support office, at all times. During absences of key clinical staff, the clinical management is overseen by one of the senior registered nurses who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by the staff. This includes management of incidents/accidents, complaints and audit activities, an annual satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint minimisation and safe practice.</p> <p>Terms of reference and meeting minutes sighted confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs, and related information is reported and discussed at the weekly team meetings, and quality and staff meetings held monthly. Minutes reviewed included discussion on pressure injuries, restraints, falls, complaints, incident/adverse events, infections, audit results and the activities programme. Staff interviewed reported their involvement in quality and risk activities through audit activities, for example, for the laundry and the kitchen. Any relevant corrective actions are developed and implemented as necessary to demonstrate continuous improvement is occurring. Resident and family surveys are completed annually and are sent out from the HLL support office. This includes younger people with a disability. The last survey was completed in October 2018. The facility manager commented that there had been a smooth transition after the change of ownership, across all areas of service delivery.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements and were current. The document control system is managed at HLL support office by the quality and compliance team. All documents are updated as required and sent out via a memorandum with instructions for replacement in the manuals. The facility manager sends back a declaration that the documents have been updated on site. This process ensures a systematic and regular review process, referencing of relevant resources, approval,</p>

		<p>distribution and removal of obsolete documents. Staff are updated on any new policies or changes to policies through the staff meetings.</p> <p>The facility manager described the process for the identification, monitoring of risks and development of mitigation strategies. The risk register is updated at head office. The service risk register showed consistent review and updating of any risks identified, risk plans and the addition of any new risks. The facility manager, clinical services manager and the quality manager are aware of and have attended training in the Health and Safety at Work Act (2015) requirements and have implemented requirements. A senior caregiver interviewed is the health and safety representative and two other staff have recently been elected for this role and/or committee.</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>Heritage Lifecare (BPA) Limited (HLL) authorised the position of the quality manager at Riverside care home and hospital as part of the transition process when purchasing this facility. The quality manager interviewed ensures any adverse event reported is dealt with immediately. The quality manager reported that addressing more minor incidents before they manifest into more significant events has been valuable for the service and that the aim of adverse event reporting is to close the 'quality loop' quickly and effectively. The incident management process is closely linked to the quality and risk management system. Incidents are now all recorded on an electronic system which has been implemented since the previous audit. The incident/accident information reviewed was fully completed, incidents were investigated, actioned and follow-up was completed in a timely manner. Adverse event data is collated, analysed and reported by the quality manager to the facility manager and clinical services manager monthly. Meeting minutes reviewed showed discussion in relation to any trends, action plans and improvements made. Corrective action plans were identified and acted upon as required by the quality and clinical services manager (CSM) who collates this information monthly and sends to the quality and compliance team at HLL support office. The FM and CSM feed back to the staff at the staff/quality meetings.</p> <p>The facility manager interviewed described essential notification reporting requirements. The service has had no notifications of significant events made to the Ministry of Health (MoH) 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</p>	FA	<p>Policies and procedures are in line with good employment practice and relevant legislation and guide human resources management processes. Position descriptions reviewed were current and defined key tasks and accountabilities for the various roles. The facility manager is responsible for the recruitment process which includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained. Employment checklists were used in the front of each individual staff record sighted. The records were well maintained.</p>

<p>meet the requirements of legislation.</p>		<p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed showed documentation of completed orientation and a performance review annually.</p> <p>Continuing education is planned on an annual basis. The in-service education schedule was sighted. Mandatory training requirements are defined and scheduled to occur over the course of the year. An education register has been developed and implemented for 2019 and a record is maintained by the quality manager. Competencies are maintained and were recorded on the competency register reviewed. Care staff have completed the required education to meet the requirements of the provider's agreement with the DHB. Education records reviewed demonstrated completion of the required training. Eight of twelve registered nurses have completed and are competent to perform interRAI assessments. Time is allocated to the staff for completing the required assessments.</p> <p>The care staff working in the dementia service are all qualified to work in this service having completed the approved dementia care levels of training required. Training to meet the needs of younger individuals with disabilities occurs.</p> <p>Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs and to review competencies. Appraisals were in progress at the time of audit and the facility manager has an appraisal schedule displayed in the office.</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>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery 24 hours a day, seven days a week (24/7). The organisation (HLL) uses 'allocation of staff/duty rosters', an electronic tool based on indicators for safe staffing, and this is used by the facility manager and the clinical services manager when preparing the rosters There is a documented rationale for safe staffing.</p> <p>The facility manager is able to adjust staffing levels to meet the changing needs of residents. An after-hours on call roster is in place with staff reporting that good access to advice is available when needed. The facility manager and the clinical services manager are on call seven days a week. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and families interviewed supported this.</p> <p>The rosters reviewed confirmed adequate staff cover has been provided with staff replaced in unplanned absences. There are registered nurses on every shift in all areas of service delivery except on the night duty where there is one registered nurse supported by three caregivers across all services. The clinical services manager and the facility manager work Monday to Friday. Adequate care staff cover the facility on all shifts with various 'short shifts' being available to provide additional support at the busy times across the twenty four hour period. Staff interviewed commented that any emergency situations are managed effectively. All staff</p>

		<p>have completed first aid courses and certificates were in the staff records reviewed. There are 12 registered nurses including the clinical services manager and facility manager. All have competencies for medication management, verification of death, wound care management, female and male catheterisation and other medical and palliative care management roles. Eight of twelve (12) registered nurses are interRAI competent.</p> <p>A reconfiguration to support the provider's application for residential, disability/physical certification was completed. The provider is suitable to provide this service. No changes will be required to the current service.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>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 information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents, both younger and older, enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Files reviewed of residents requiring dementia level care showed evidence of been seen by a specialist. Being deemed incompetent to make an informed choice, the resident's enduring power of attorney have signed the admission agreement giving consent for the resident to be admitted. 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 NASC 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>A reconfiguration to support the provider's application for residential, disability/physical certification was completed. The provider is suitable to provide this service. No changes to the current service will be required.</p>
Standard 1.3.10:	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate.

<p>Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>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. An example reviewed of a patient recently transferred to the local acute care facility showed clear and ongoing communication between the facility, acute services and family. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and 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 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 with six monthly audits and as required.</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 and six-monthly 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.</p> <p>There were no residents self-administering medications at the time of audit. The registered nurse interviewed stated that there were no barriers to young residents who wanted to self-administer medications as long as they were deemed safe to do so. Appropriate processes were in place to ensure this was 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</p>	<p>FA</p>	<p>The food service is provided on site by a kitchen manager/cook (not available for interview at the time of audit), a further three cooks and kitchen team, and is in line with recognised nutritional guidelines for older people.</p>

<p>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>The 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 New Plymouth District Council which expires December 2020. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have undertaken a safe food handling qualification.</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 to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>All food is cooked on site and served directly to the adjacent rest home dining room and dementia and hospital dining rooms by mobile hot boxes. Residents also have the option of having meals in their rooms.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for 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</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, challenging behaviours, 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. All residents have current interRAI assessments completed by one of eight trained interRAI assessors on site and this includes the clinical services manager. Residents and families confirmed their involvement in the assessment process.</p>

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<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of all residents, young and older, 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. Residents' files reviewed in the dementia unit had behaviour management plans which identified triggers and interventions for behaviours which are integrated into a 24-hour activity plan</p> <p>Care plans evidenced 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> <p>No changes will be required to the current service to meet the needs of young people with a disability.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care provided is 'holistic'. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy. The residents are supported in the rest home and hospital area Monday to Friday 8.30 am to 5.00pm and in the dementia unit Monday to Friday 9.30 am to 4.00 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 three monthly and 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, satisfaction surveys and day to day discussions. Residents interviewed confirmed they find the programme meets their needs. The diversional therapists interviewed stated that the residents from the rest home, hospital and dementia units integrate most days with activities, but that the dementia unit has its own calendar.</p>

		<p>The facility supports six young persons with disabilities whom are supported and encouraged to partake in activities of interest within the facility and out in the community. Each resident has an individual activity plan with the majority of the young persons regularly attending different daily and weekly activities provided by a local iwi community programme. The programme provides support with, for example, cooking classes, swimming, wellness walks, gym, gardening, shopping and van trips. For young people who choose not to partake in activities, one to one support is provided in the form of regular daily visits by the community group with one person who is supported to attend a separate day programme based in the community.</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 distraction, one to one support and activities of interest highlighted for each resident over a 24-hour activity plan. The residents in the dementia unit also have access to an outside garden which has a car, letter box, bus stop and garden that residents can interact safely with as part of their daily activities of living.</p>
<p>Standard 1.3.8: Evaluation 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. 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, wounds and falls. When necessary, and for unresolved problems, long term care plans are added to an 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) 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. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to a physiotherapist, dietician, speech language therapist, and mental health services. 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>	<p>FA</p>	<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 (blood and bodily fluids) management and disposal. A contracted company removes all re-cycling and cardboard waste and normal waste is collected by the council weekly and as needed. There is a designated area for storing chemicals used for cleaning and the laundry which is securely locked. All containers in use are clearly labelled. An external company is contracted to supply and manage chemicals and cleaning products and they also provide relevant training for staff. Training was provided on the 04 July 2018 on chemical safety in the workplace and twenty six (26) staff attended. Material data sheets were available where chemicals are stored and used and staff interviewed knew what to do should any chemical spill/event occur. Any related incidents are reported in a timely manner. The maintenance person was unavailable for interview at this audit.</p> <p>There is adequate provision and availability of protective clothing and equipment and staff were observed using this including gloves, aprons and hats.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A building warrant of fitness is current and was displayed at the entrance to the facility with an expiry date of 15 December 2019. All maintenance information is now directly transferred onto the electronic system. The service is currently transitioning from hard copy records to electronic.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and the facilities are fit for purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate and safe standard. The testing and tagging of equipment and calibration of medical equipment was current and confirmed in documentation reviewed. An equipment validation report was reviewed. All hoists are included in the checks and oxygen concentrators are ready for use. There are oxygen cylinders on site but these can be refilled and ordered if and when required.</p> <p>The grounds are safely maintained and were appropriate to the resident groups and the setting. Pathways were even for younger and older residents using mobility wheelchairs and/or total mobility scooters. There is a designated covered deck area provided for charging up the batteries when mobility aides are not in use. The environment is conducive to the range of activities undertaken. The environment was hazard free and residents were safe. Staff interviewed confirmed they knew the processes they should follow if any repairs or maintenance was required and that any requests are appropriately actioned. The residential care service has an external area with a raised garden and even pathways to walk around the facility. Residents reported they were happy with the environment.</p> <p>No changes will be required to the current facilities or equipment to support the reconfiguration of service to accommodate young persons with a disability.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is a mix of toilet, showers and bathing facilities in the three areas of service delivery. This includes rooms with ensuites, shared bathrooms between rooms and additional bathroom areas. All individual resident's rooms have a hand basin except for the rooms in the dementia service. Appropriately secured and approved handrails are provided in the toilet/shower areas and other equipment/accessories are available to promote residents' independence.</p> <p>A reconfiguration to support the provider's application for residential, disability/physical certification was completed. The provider is suitable to provide this service. No changes will be required to the current service.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate space provided to allow residents and staff to move around within the bedrooms safely. All bedrooms provide single accommodation. All rooms are personalised with furnishings, photographs and other personal items being displayed.</p> <p>There is room to store mobility aids, walking frames and wheelchairs. Staff and residents interviewed reported the adequacy of bedrooms. Hoists sighted were stored in a designated area and did not impede walkways or create a hazard for mobile residents. There is one area located near the dementia service just for storage of total mobility scooters.</p> <p>A reconfiguration to support the provider's application for residential, disability/physical certification was completed. The provider is suitable to provide this service. No changes will be required to the current service.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is one communal lounge/dining available for residents to engage in activities in the dementia service. The dining and lounge areas in the rest home are spacious and enable easy access for residents and staff for activities, functions and when entertainment is provided. Access to the lounge and dining rooms is provided for younger and older disabled residents to facilitate easy access with wheelchairs, walkers and electric powered mobility aids. The hospital has a smaller functional lounge. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs are met. The furniture is arranged in a manner which enables residents to mobilise freely.</p> <p>The needs of young people with a disability can be catered for within the current facility layout.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is undertaken on site in one large laundry. Facilities are readily available in the laundry sighted. Resident's personal laundry items are laundered on site or by family members if requested. Residents and family members interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently washed by dedicated laundry staff during the daytime hours. The laundry person interviewed was very experienced. There is one designated staff member for the laundry and a relief laundry person available. After hours the care staff are responsible for the laundry. The staff member interviewed demonstrated a sound knowledge of the laundry processes, dirty to clean workflow and handling of soiled linen.</p> <p>There are two designated cleaners who are fully trained, including training on infection control, products and protocols. The cleaners cover the total facility inclusive of the dementia service. Material data sheets are available for all products in use. A chemical spills kit is available if and when needed. The cleaning trollies are stored appropriately when not in use in the locked sluice room. Chemicals are refillable, and all containers used were adequately labelled. Cleaning and laundry processes are monitored through the internal audit programme and by the company representatives (service reports were available). Chemical safety training for staff was provided in July 2018 with a good attendance recorded. On all shifts, additional designated cleaning schedules were completed by care staff.</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 duties direct the facility in their preparation for disasters and describe the procedures to be followed in the event of fire or other emergencies. The current fire evacuation plan was approved by the New Zealand Fire Service, the most recent being the 11 July 2013. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent being the 14 November 2018. The local fire service attends the fire drills and provides feedback to the staff. The staff orientation programme includes fire and security training and training is provided as part of the ongoing education calendar sighted. Staff interviewed confirmed their awareness of the emergency procedures and how to evacuate the younger and older residents with physical disabilities and the residents in the secure dementia service if and when required.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water and blankets, mobile phones, torches, lanterns and gas barbecues were sighted and meet the requirements for the Taranaki Council in this region. Storage of water potable water was evidenced and the supplies are changed three monthly. The emergency lighting which is regularly checked lasts approximately three to four hours. A battery pack is available for beds for lowering the high low beds if needed. Back up batteries are available for security of main doors. The service does not have a generator but is prioritised in the region for energy power supply as soon as available. Emergency protocols are linked with the DHB if required and contact details of other aged care providers are accessible in the event of an emergency in this region.</p>

		<p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families interviewed reported staff respond promptly to call bells.</p> <p>Security arrangements are in place and staff ensure all doors and windows are locked at a predetermined time in the evening and are again checked by the night staff routinely.</p> <p>No changes will be required to the current service to accommodate the needs of the younger people.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' individual rooms and communal areas have opening external windows with natural light. Electric heating is provided throughout the facility. Additional heat pumps are available in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facility is maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the GP, pharmacy and local district health board as required. The infection control programme and manual are reviewed annually.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical services and facility managers and tabled at the registered nurse, full staff and quality/risk committee meetings. This committee includes the clinical services manager, facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has recently taken over the role of infection control nurse from the clinical services manager who stated they will continue to support the person in this role. Both the clinical services manager and infection control coordinator have undertaken post graduate training in infection prevention and control and attended relevant study days, as</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</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 reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in March 2018 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training was documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. As part of corrective actions that have been implemented, records showed tool box sessions provided for staff when monthly surveillance results showed an increase in respiratory tract infections in February 2018 and an increase in skin and chest infections in October 2018.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</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>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. Trends are identified from the past year and this is reported by the clinical services manager to the facility manager. 100% of residents and 67% staff consented to the flu vaccine in April 2018.</p> <p>The facility has had a total of 30 infections from July 2018 through to and including December 2018 with no residents identified with frequent infections over this time. One resident's file reviewed, due to a history of chronic infections, highlighted short term and long-term care planning to reduce and minimise the risk. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked externally within the larger HLL organisation three monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. The clinical services manager reported no infectious outbreaks 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>Policies and procedures reviewed October 2018 meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. A flow chart is also available to guide staff. The restraint coordinator provides support and oversight for enabler and restraint management in the facility when required and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the days of audit one resident was using a restraint and one resident was using an enabler which was the least restrictive and used in a voluntary capacity at the request of the resident.</p> <p>Restraint is only used as a last resort when all alternatives have been explored. This was clear on review of the restraint approval group minutes and records reviewed and staff interviewed.</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</p>	<p>FA</p>	<p>The restraint approval group is an organisational group which provides leadership and oversight of restraint across the organisation. Membership consists of the national manager clinical and quality (chair), the clinical and quality improvement lead, two clinical managers and two restraint co-ordinators. The restraint approval group convenes twice a year, approves restraint methods for the organisation, monitors restraint uses within the organisation and approves policy change. The last restraint audit was completed 29 November 2018 and the quality meeting minutes were available for review. The coordinator understands the lines of accountability and that the one restraint has been approved and is monitored and analysed. Evidence of family/EPOA involvement was observed in the record reviewed. Use of a restraint or an enabler is part of the plan of care as was sighted in the electronic records maintained.</p>

process is made known to service providers 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 facility manager described the documented process. 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. A completed assessments was sighted in the one resident's individual record reviewed who was 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 facility manager described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats and low beds and fall out mattresses). When a restraint is in use frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. A family advocate is available if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained and updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained the details of the one resident using a restraint and the information was sufficient to provide an auditable record.</p> <p>Staff have received training in the newly implemented policy and procedures and in related topics such as positively supporting people with challenging behaviours. Staff spoken to clearly comprehended 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' records showed that individual use of restraint is reviewed and evaluated during the care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Family interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the</p>	FA	<p>Quality reviews occur within the appropriate timeframes as per the newly implemented restraint minimisation and safe practice policy reviewed to meet the requirements of the Standard. Education is provided to all staff at orientation and is ongoing. The last restraint training was provided 6 December 2018. Restraint reports are completed, and individual use of restraint is reported to the national manager clinical and quality. A six monthly internal audit is carried out which also informs the quality meetings. Data reviewed, minutes of meetings and</p>

monitoring and quality review of their use of restraint.		staff interviews confirmed that the use of restraint has been reduced.
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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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.