

Heritage Lifecare (BPA) Limited - Highfield Rest Home

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: Highfield Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 4 February 2019 End date: 5 February 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: 41

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

Highfield Rest Home provides rest home care for up to 44 residents. The service is operated by Heritage Lifecare (BPA) Limited and managed by a facility manager and a 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. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, and a general practitioner.

This audit has resulted in a continuous improvement in infection surveillance. There are no areas identified for improvement.

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

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. A comprehensive Māori health plan and related policies guide care.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

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

There is a complaints process that is understood by residents, family members and staff and meets the requirements of the Code. 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 scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body 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. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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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The organisation works closely with the local Needs Assessment and Service Co-ordination Service (NASC), to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission, within the required time frames. Registered nurses are available 24 hours each day in the facility and are supported by care and allied health staff and designated general practitioners. Shift handovers and communication notes guide continuity of care.

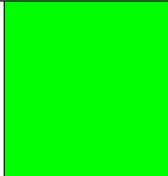
Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by an activities co-ordinator, provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and senior care staff, all of whom have been assessed as competent to do so.

The food service is prepared and delivered on site and meets the nutritional needs of the residents with special needs catered for. Residents and their family/whānau 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.

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 implemented policies and procedures that support the minimisation of restraint. No enablers nor restraints were in use at the time of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets bi-monthly. Specialist infection prevention and control advice is accessed from the district health board (DHB), microbiologist, infectious diseases physician, and group clinical advisory committee. The programme is reviewed annually.

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, data is analysed, trended, 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	45	0	0	0	0	0
Criteria	1	92	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Highfield Rest Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). A welcome pack and letter are prepared for each in coming resident and their family. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options to residents and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There is an informed consent policy, which provides guidance to staff. Registered nurses and care staff interviewed understand the principles and practice of informed consent and have received education on induction and as part of the annual education plan. Clinical records reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, visits from the GP and outings. Individual consent forms were sighted for vaccination, and valuables.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's record. Evidence of a legally appointed EPOA when a resident is unable to give their own consent was</p>

		<p>present in the clinical records. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p> <p>Residents and family/whānau interviewed were able to give examples of when verbal and written consent was obtained.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents and family members are provided with information on the Code and the Advocacy Service and the facility identifies resident's next of kin or Enduring Power of Attorney or welfare guardian as evidenced in the clinical record. If there is no-one identified, and the resident is in need of assistance or the resident requests assistance, they will be provided with advocacy network services and the HDC contact numbers. Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed at staff interviews.</p> <p>Posters related to the Code and Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Residents and family/whānau interviewed confirmed an information pack on admission was supplied to them which included the Code of Rights and a pamphlet on the advocacy service and the clinical services manager had discussed all information in the pack with them. They were aware of their right to complain, how they would do this, their right to have a support person if required and the availability of an advocacy service and how to access this. None of the residents/family/whānau have had to access this service as they stated they were 100% satisfied with the care.</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. The facility supports the philosophy of "The continued pursuit of excellence in care through monitoring, auditing, auctioning and evaluation of service whilst respecting and valuing our residents, families and staff" to the highest level of independence.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family/whānau and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff, they could stay as long as they required, attend social events and could have family gatherings at the facility. They were encouraged to have continuing involvement in the day to day care.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>Heritage Lifecare (BPA) Limited - Highfield Rest Home (Highfield) complaints and concerns policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Copies are also available at the front entrance of the facility.</p> <p>The complaints register reviewed showed that two complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager (FM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service) through the facility manager and clinical services manager as part of the admission process, the welcome pack and letter information provided, and during discussions with staff. The Code is displayed in a visible location at the entrance way to the rest home.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>The service ensures that the residents' rights to privacy and dignity are recognised and respected at all times. Staff understood the need to maintain privacy and were observed doing so throughout the audit while. Residents are encouraged to maintain their independence by staff ensuring individual care plans are followed, encouraging attendance at community activities, participation in clubs of their choosing, and having family gatherings for birthdays and anniversaries in a private lounge on site. Family/whānau are encouraged to have meals with their family member and attend MDT meetings, activities and residents' meetings to give feedback as confirmed in interviews with family members. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Staff have had training from Ear Health and the Foundation for the Blind to promote and ensure best practice for caring for and maintaining hearing aids. Those residents affected by decreasing eyesight are registered with the Foundation for the Blind, have appropriate equipment and are taken to the social events.</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 is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records. Interviews with residents and family/whānau confirmed they had not witnessed any abuse or neglect while in the facility.</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 underpin the Māori health strategies developed and are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori Health Plan developed with input from cultural advisers (updated April 2017). There is also the Māori perspective of health guide document which provides information about Māori beliefs in relation to illness, the Te whare tapa wha model of health and an outline of cultural belief experiences in relation to health in the context of Aotearoa New Zealand.</p> <p>Current access to resources includes the contact details of the Director of local Māori Health at the DHB, local cultural advisers and all residents identifying themselves as Māori are offered the opportunity to have iwi, hapu and/or whānau contacted and present whenever desired, including for assessment and review of care. Staff receive education on cultural awareness during orientation to the service and annual in-service training as per education programme. Staff assist and support the resident and their whānau with spiritual and cultural requests and recognise use of Māori protocol, for example, karakia, waiata and whanaungatanga as appropriate. On the days of audit there were no residents who identified as Māori in residence.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The quality risk management plan and a cultural safety policy states that services will be delivered in a culturally safe manner to all residents, family/whānau and staff and acknowledges each individual's spiritual and cultural values, beliefs and needs. Staff receive education on cultural safety at orientation and bi-annually and could describe culturally safe practices.</p> <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 any special requirements, including dietary needs were identified on admission and their preferences documented in all care plans reviewed. Cultural values, beliefs, spiritual, social and recreational needs were included in all care plans reviewed. Interviews with residents and their family/whānau confirmed that staff ensure the residents' needs are met. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supported 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>The induction process for staff includes education related to the Code of Conduct which provides a very detailed set of behavioural parameters, professional boundaries and expected behaviours for staff to follow. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet, their individual employment contract and the Code of Conduct policy, and the Elder Abuse and Neglect policy. Staff interviewed demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. Staff were aware that the Code requirements must be met in their daily work in the facility.</p> <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner interviewed also expressed satisfaction with the standard of services provided to residents, was not aware of any incidents of elder abuse or neglect occurring in the previous twenty years of attending the facility, and reported that residents were safe at Highfield Rest Home.</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 diabetes nurse specialist, physiotherapist, occupational therapist, social workers, wound care nurse specialists, community dietitians, a psycho-geriatrician, mental health services for older persons, and links with the local community.</p> <p>Registered nurses were observed promoting, advising and encouraging best practice with the caregivers on duty on the days of audit. There is regular in-service training for staff and external programmes available. Staff reported they receive management support for internal and external education through Careerforce training, Healthlearn and there was evidence of a compulsory plan for all staff where staff are booked to attend education to support contemporary good practice.</p> <p>The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required, staff were responsive to medical requests and treatment plans. The GP interviewed is also available by cell phone and text messaging ensuring he is available in a timely way for advice if any changes occur with residents.</p> <p>There is an electronic 'eCase' system for assessment, documentation, planning and evaluation which provides clarity and accountability around documentation. All interRAI care plans were current and informed the care planning process. Falls assessment and monitoring were documented and occurring with sensor mats in place and half hourly checks. Pressure injury prevention assessments and strategies were documented on eCase with pressure prevention mattresses and 'roho' cushions in place. On the days of audit there were no pressure injuries reported in the facility.</p>

		<p>Other examples of good practice observed during the audit included extra fluid rounds, prompt answering of call bells, knocking on doors prior to entering the resident's room and regular toileting rounds. Residents and family/whānau interviewed confirmed their needs are promptly met and of an appropriate standard.</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>The service has an interpreter policy and a list of contact details of available interpreters. Interpreter services can be also be accessed via the DHB or Older Persons Health when required. Staff knew how to do so, although reported this was rarely required due to all residents able to speak English. Staff can provide interpretation as and when needed with the use of family members, and communication cards which are available for any potential residents for whom English is not their first language.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Residents and family/whānau members interviewed stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and were involved in regular and any urgent medical reviews, or if unable to attend, outcomes were reported to them. This was supported in residents' records reviewed where evidence of regular communication with family/whānau was documented. There was also evidence of resident/family/whānau input into the assessment and care planning process, re-evaluations and activity programme.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Heritage Lifecare Limited (HLL) uses a standard template for the organisation's business plans for each site. Highfield Rest Home has site specific objectives, which link to the organisation's quality plan objectives.</p> <p>The FM reports weekly and monthly to HLL. The weekly report is on occupancy, general comments on movements, health and safety and compliance issues (incidents/accidents), new risks identified, and any outstanding issues. The general manager clinical and quality transfers these to the organisation's risk register and / or updates the register as needed. Compliments and complaints, staffing and HR issues including training, property and environment issues and general comments are included. Weekly reports are reviewed at operations level and a report by this team to the senior executive at a monthly meeting.</p> <p>The monthly report includes clinical indicators and interRAI assessment information. Indicators include falls with and without injury, pressure injuries, urinary tract infections (UTIs), skin tears, bruising, behavioural events, wound infections, acquired infections, and the clinical managers (CSM) or FM sends a narrative report with the data report. Based on these reports a spread sheet with graphs is collated at HLL head office and the Q&C manager prepares a compliance report to the GM and board.</p>

		<p>Highfield Rest Home is managed by a FM who holds relevant qualifications and has been in the role for four years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through HLL training update days and sector meetings.</p> <p>The service holds contracts with the South Canterbury District Health Board for rest home level care and for one mental health resident. Twenty-six residents were receiving services under the rest home contract and one resident under the MH contract at the time of audit. There were also 14 residents who were private paying.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the FM is absent, the CSM carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by another registered nurse (RN) 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>
<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>HLL has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and concerns/complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and interRAI outcomes. It is detailed and specifies the roles and responsibilities of all staff members, in particular the FM and CSM. The FM has developed the quality plan and goals, maintains the document management and control in the facility and is responsible for monitoring and reporting on progress against the quality goals in her weekly manager's report. The CSM's responsibilities include providing clinical leadership in the facility for the implementation of the plan, providing educational support for the staff and RNs, and providing early warning to the FM on risks.</p> <p>Document control is managed at HLL head office by the general manager clinical and quality. All documents are updated and sent out via memo with instructions for replacement in manuals in hard copy. FMs are requested to send back a declaration that the documents have been updated on site. 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 reviewed are based on best practice and were current.</p> <p>There are terms of reference for the committees which are held at Highfield; restraint standards approval,</p>

		<p>quality, health and safety, resident care review, resident and family, staff meeting, registered nurses. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at all management, clinical and staff meetings.</p> <p>There is an internal audit schedule within the quality improvement plan. This sets out a comprehensive programme of audits across the year to monitor all aspects of the service.</p> <p>Training is provided to all staff annually on the quality and risk management system, including incidents, accidents, complaints, hazards and risks. Staff reported their involvement in quality and risk management activities through audit activities, meetings and training.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey showed cleaning and food at tea time as an issue for a small number of respondents. The service addressed the food issue at the residents' meeting with a positive result. The FM provided additional cleaning over the winter months to improve the cleaning. Residents confirmed that the issues have been addressed.</p> <p>The FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The organisation's standard risk management plan includes Highfield's site-specific risk register. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form and transferred to the electronic reporting system. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the HLL management team.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries. Essential notifications are the responsibility of the general manager clinical and quality. FM's report incidents/accidents as noted and serious events are included in this. They advised there have been two notifications of significant events made to the Ministry of Health, since the previous audit. One (a power outage) has been resolved, and the second is a recent medication event and the investigation into this is in progress.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>FA</p>	<p>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. A sample of staff records reviewed</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after three-months and then annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Eight care staff have either completed or commenced a New Zealand Qualification Authority education programme which is voluntary. A staff member is the internal assessor for the programme. All staff complete training to meet the requirements of the provider's agreement with the DHB. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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 facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of four weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review.</p> <p>Clinical notes were current and integrated with GP and allied health service provider notes. 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. Resident's files are held for the required period before being destroyed.</p> <p>No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their</p>

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>families/whānau are encouraged to visit the facility prior to admission and meet with the Facility Manager (FM) and/or Clinical Service Manager (CSM) when written information about the service and the admission process is provided. Pre-entry screening is carried out by the FM whose role is to keep notes of the meeting and the CSMs role is to determine suitability of placement. The decision on whether the resident is to be admitted is made within 48 hours. The screening to entry is to determine any potential risks involved in the provision of service. The service operates a waiting list for entry.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them prior to admission and on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The general practitioner confirmed the facility notifies and transfers in a timely manner ensuring the resident and family members are consistently communicated with throughout the process. 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. At the time of transition between services, appropriate information, including medication records, 24 hours of medication, 24 hours of progress notes, wound charts (where applicable), and any advance directives are provided for the ongoing management of the resident. A checklist ensures this occurs. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility, showed a planned, co-ordinated transfer to the acute care service and transition back again. Family members of the resident were kept well informed during the transfers of their relative as evidenced in documentation in the family notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is currently under review 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 was observed on the day of audit with the registered nurse wearing a green apron, identifying not to be disturbed as the medication round was in progress. 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 and have completed annual medication competencies and medication education.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription and any pharmacy errors are</p>

		<p>recorded and fed back to the supplying pharmacy. The pharmacist collects medications and replaces controlled drugs. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly, stock on hand and six monthly stock checks and accurate entries. Standing orders are not used.</p> <p>Residents who self-administer medications have a competency assessment and appropriate processes and documentation are in place to ensure this is managed in a safe manner as verified at audit. Pain assessments were well documented in response to analgesia administered.</p> <p>Medications are stored and managed in line with legislation and guidelines and the records of temperatures for the medicine fridge has temperatures recorded daily and these were within acceptable ranges. There were no expired medications.</p> <p>An electronic system is in use 'Medimap' with best practice prescribing noted, including identification of the prescriber and the date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly general practitioner review is consistently recorded on Medimap with prompts before the review is due. The pharmacist has access to the Medimap system and medication reconciliation is occurring.</p> <p>Medication errors are reported to the clinical services manager and recorded on the incident reporting system, which alerts the facility manager and quality and risk co-ordinator. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by the kitchen manager and kitchen assistants and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been developed by a qualified dietitian in November 2018. 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. Documentation of temperatures of inwards goods arriving is occurring with temperatures recorded on arrival to the facility. Fridge/freezer temperatures of stored foods were consistently being recorded and documented daily.</p> <p>The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A food control plan was audited and signed off on the 21st June 2018 for the facility.</p>

		<p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The kitchen manager is notified of any allergies, dietary changes, weight loss or other dietary requirements. 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 have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available and was observed in use.</p> <p>Evidence of residents' satisfaction with meals was verified by resident and family interviews, satisfaction surveys, whereby residents have the opportunity to contribute to the content of menus, and in resident meeting minutes. Residents were observed to be given sufficient time to eat their meal and those requiring assistance had this provided. There were enough staff on duty in the dining rooms at meal times to ensure appropriate assistance and staff were observed assisting residents on both days of the audit.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>Any decision to decline entry to the facility is covered in the policy resident screening and selection. When declining entry, either because the prospective resident does not meet the entry criteria or there is currently no vacancy, a meeting is arranged with the resident and/or their family or advocate and the decision to decline entry is conveyed. The local NASC service is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC service is made and a new placement found, in consultation with the GP, resident and family/whanau. Examples of this occurring were discussed with the CSM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The sample of care plans reviewed had an integrated range of resident related information. All residents' files reviewed had a current interRAI assessment which informed the individual care plan and life style plan. Short term care plans were implemented when needed, re-evaluated and either signed off or transferred into the long term care plan. The needs, goals, outcomes were identified from the assessment process and documented to inform service delivery planning.</p> <p>Information is documented using a range of validated nursing assessment tools, for example, the Norton scale risk assessment tool, Abbey falls assessment tool, nutritional assessment tool and profile, continence assessment, oral assessment, pain assessment, pressure injury risk assessment, depression scale, cultural assessment and life style assessment. These, and other assessments identify any deficits and informed care planning.</p> <p>Residents/family/whānau confirmed they were involved in the assessment process.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The 'Guidelines for writing care plans' stated that residents will have a care plan developed within 24 hours of admission. An individual lifestyle plan is developed within three weeks of admission and this was seen in all files reviewed in 'eCase'. Short term care plans are developed in response to specific problems and kept on the resident's file for as long as needed. If the problem continues, it is included in the long term care plan. The guidelines documents include frequency of reviews (See standard 1.3.8).</p> <p>All care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidenced service integration with progress 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. Clinical staff have annual training in care planning.</p> <p>Residents and families/whānau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident. The general practitioner interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard at Highfield Rest Home. The facility manager, clinical service manager, registered nurse, diversional therapist and care staff confirmed that care was provided as outlined in the documentation.</p> <p>The education programme for clinical staff lists a range of topics to be delivered annually, including nutrition and hydration, promoting continence and managing incontinence, skin management and pressure area prevention, wound care, observing and reporting, pain management, falls prevention – mobility and safe transfers.</p> <p>A range of equipment and resources were available, suited to the level of care provided and in accordance with the resident's identified needs, as observed at audit.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>The activities programme is co-ordinated by the activities co-ordinator and one diversional therapist who works on a casual basis. Between them they provide activities across five days a week. The activities co-ordinator was on leave at the time of the audit. The diversional therapist was interviewed who is responsible for taking residents out on van outings.</p> <p>A social assessment and life history is undertaken on admission to ascertain residents' needs, interests,</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>abilities and social requirements. Activities assessments which include the resident and their family/whānau members are regularly reviewed to help formulate an activities programme that meets the individual needs and interests of the resident. The resident's activity needs are evaluated as their needs change, monthly, and as part of the formal six monthly care plan review. The individual activity plan was reviewed at the same time as the care plan in all residents' files reviewed.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities, exercise classes and regular events are offered. One on one activities are organised for those who choose not to join the group activities or have special needs. Interdenominational church services occur weekly at the facility. The physiotherapist or trained staff undertake a mobility/exercise programme with groups and individually on a daily basis as observed at audit.</p> <p>The activities programme is discussed at the residents' meetings, to which residents and family/whānau are invited, and their input is sought and responded to. Residents and family members interviewed confirmed this is occurring. Residents' minutes and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes daily. If any change is noted, it is reported to the registered nurse or clinical service manager. General practitioner reviews occur three monthly. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the clinical service manager. 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 were noted for urinary tracts infections (UTIs), falls, infections, and any changes in the resident's normal status. Progress was evaluated as clinically indicated at least weekly and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressing was changed.</p> <p>Residents and families/whānau interviewed provided examples of involvement in evaluation of progress.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. All residents have the choice of their own general practitioner. If the need for other non-urgent services are indicated or requested, the general practitioner, clinical service manager or registered nurse sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the physiotherapist, occupational therapist, gerontology clinical nurse specialist, oncology support service,</p>

<p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>wound care specialist, and older persons' mental health. Referrals are followed up on a regular basis by the registered nurse or the general practitioner. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff and audit for effectiveness.</p> <p>Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 01 May 19) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe, and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to the resident group and setting, as observed during the audit.</p> <p>Staff confirmed they knew the processes they should follow if any repairs or maintenance was required and that requests are appropriately actioned. Residents reported that they were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a small number of rooms with shared ensuites. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids and wheel chairs. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry. Laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There are two designated cleaning staff who have received appropriate training, as confirmed in interview and review of training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and by an external contractor.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and</p>

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 29 Nov 2005. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 11 December 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the full number of residents. Water storage tanks are located around the complex. Emergency lighting is regularly tested. The facility has a memorandum of understanding with another facility to shelter residents if required in an emergency. The organisation has a process in place to ensure a generator is available if required.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and most have doors that open onto outside garden or small patio area. Heating is provided by thermostatically controlled ceiling heaters in residents' rooms and in the communal areas. Areas were comfortable and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the clinical services manager/infection prevention and control officer (IPC). The infection control programme and manual are reviewed annually and due for review next in March 2019.</p> <p>The clinical service manager/registered nurse, with support from the facility manager 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 facility manager and tabled at the quality/risk committee meeting. There is a bimonthly IPC meeting which includes all staff, and minutes are available for staff. Regular audits have been conducted and education has been provided for staff, residents, family members and visitors.</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 related responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection prevention and control (IPC) coordinator has appropriate skills, knowledge and qualifications for the role. The infection control co-ordinator has been in the role for the previous five years and has completed recent ongoing training. The facility manager supports the IPC co-ordinator. Well-established local networks with the infection control nurse specialist, district health board, infectious diseases physician, and Older Persons Health are available and expert advice from the laboratory can be sought if additional support/information is required. The IPC coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available and was observed being used by staff.
Standard 3.3: Policies and procedures 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.	FA	The infection prevention and control policies and IPC programme are current and reflect the requirements of the infection prevention and control standard and current accepted good practice. Caregivers, 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 and had had recent training in infection prevention and control.
Standard 3.4: Education The organisation provides	FA	Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control

<p>relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>at orientation and ongoing six monthly education sessions. Education is provided by suitably qualified IC registered nurses, and the infection prevention and control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>When an increase in infection incidence has occurred, there was evidence that additional staff education had been provided in response. There has not been an infection outbreak in the facility since the previous audit.</p> <p>Education with residents is on a one-to-one basis and has included, reminders about hand washing, advice about remaining in their room if they are unwell, increasing fluids to prevent urinary tract infections and extra fluids in hot weather. Families confirmed they were also advised by staff that if unwell not to enter the facility and were educated about cough technique and hand washing. Discussion on IPC occurs at residents' meetings which relatives were invited to.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the individual infection register in the resident's clinical record, infection reporting form, and resident management system. The infection control coordinator reviews all reported infections. There has been improved outcomes for residents with a 75% reduction in respiratory infections in residents following a project implemented and reviewed end of 2018 comparing the previous three years data. This has demonstrated continuous improvement.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Surveillance is conducted and data reported through the clinical service manager KPI indicator report to the facility manager and quality team where data is graphed, analysed and benchmarked against other Heritage Lifecare facilities. This is reported to the national clinical and quality manager and the executive board. Results of the surveillance programme are shared with staff via regular staff meetings, at staff handovers and a spread sheet is put on the staff notice board as confirmed at meeting minutes sighted and interviews with staff. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound</p>

<p>use of restraint is actively minimised.</p>		<p>understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers. There have not been any restraints used for at least eight years according to the CSM.</p>
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Specific results for criterion where corrective actions are required

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>While evaluating surveillance data over three years the service identified a higher number of respiratory infections in 2015 and in 2017, a slight reduction had occurred in 2016. Considerations were explored that South Canterbury has a higher than average influenza rate and that as a rest home only facility, many residents were accessing the community more. The goal was to reduce the number of cases of respiratory infections by December 2018.</p> <p>The service introduced the following initiatives to assist with this, beginning with staff infection prevention and control education, with a focus on staff then providing training to residents and their family/whānau on hand hygiene. The number of hand sanitising dispensers in the facility were increased and all staff were provided with pocket hand sanitisers. Infection control prevention is an agenda topic for resident /family whānau meetings and preventions discussed, such as cough technique and hand hygiene demonstrations. Hand hygiene is routine for all residents prior to meals and group activities. Residents admitted or returning from hospital and with early signs or symptoms of cough or cold remain in their rooms for 48 hours; this is also notified by newsletter.</p> <p>Following a review of the initiatives, the following additional changes were</p>	<p>An IPC project was initiated, implemented and re-evaluated from the previous three years data and findings were that the facility had demonstrated improved outcomes for residents through their IPC initiatives by a 75% reduction in respiratory infections in total in 2018.</p>

		<p>implemented: the introduction of weekly clinical meetings to enhance the monitoring of “at risk” residents; cuff first gloves were introduced under the new ownership of the facility; and additional staff education on infection prevention was provided by an external expert in infection prevention.</p> <p>An evaluation has occurred that demonstrates improved outcomes for residents including a 75% (13 infections in total for 2018) reduction in respiratory infections. The influenza numbers in the community have remained high but vigilance at Highfield Rest Home has seen a marked reduction in chest infections by December 2018. All initiatives are now standard practice at the rest home.</p>	
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End of the report.