# Heritage Lifecare Limited - Princes Court Lifecare

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Heritage Lifecare Limited

**Premises audited:** Princes Court Lifecare

**Services audited:** Dementia care

**Dates of audit:** Start date: 28 February 2019 End date: 1 March 2019

**Proposed changes to current services (if any):** Potential purchase by another provider

**Total beds occupied across all premises included in the audit on the first day of the audit:** 33

# Executive summary of the audit

## Introduction

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

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

## General overview of the audit

Princes Court rest home provides rest home dementia level care for up to 35 residents. The service is operated by Princes Court Limited – Princes Court Dementia and managed by a nurse manager and a business manager. Residents and families spoke positively about the care provided. A representative from the prospective purchaser was onsite during the audit.

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

This audit has resulted in the identification of areas requiring improvement relating to corrective actions, residents’ records, medications and restraint management.

## Consumer rights

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents. Staff are provided with training on the Code, and it is discussed with family members and residents at the time of admission and thereafter as required.

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

Systems are in place to enable any resident who identifies as Māori to have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There is 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 and information about advocacy services is readily available.

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

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

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 owners 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. Up to date, legible and relevant residents’ records are maintained using an integrated hard copy file.

## Continuum of service delivery

The organisation works closely with the local Needs Assessment and Service Co-ordination Services. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission. Admission to the facility is undertaken in a sensitive and efficient manner.

Following admission, residents’ needs are assessed by the multidisciplinary team within the required timeframes. Care and support are provided to residents by a team of registered nurses and an enrolled nurse, allied health professionals and a designated general practitioner. An on-call system is in place that ensures staff have 24-hour access to appropriate clinical and management expertise when required. Shift handovers and communication sheets 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. Families interviewed reported being well informed and involved in care planning and evaluation. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. An enrolled nurse and senior caregivers, who are the key staff administering medicines, have been assessed as competent to do so.

A nutritional assessment is completed when a person is admitted, and a copy is provided to the kitchen staff. The food service meets the nutritional needs of the residents with personal preferences and any special dietary needs catered for. A food safety plan and relevant policies guide food service delivery. The kitchen was well organised, clean and meets food safety standards.

## Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There was 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

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Two restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff training occurs annually.

## Infection prevention and control

The infection prevention and control programme aims to prevent and manage infections and is reviewed annually. It is led by an experienced and appropriately trained infection control coordinator who undertakes the role according to a detailed role description. The infection control coordinator has good access to specialist infection prevention and control advice when required.

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 with analysis and trending of infection data occurring. Follow-up action is taken as and when required. Relevant information is conveyed to quality meetings and to staff to support the prevention and control of infections.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 46 | 0 | 2 | 2 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 2 | 2 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Princes Court 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. 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 sighted. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understand 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 that includes options of consent for having their name on the door, photographs for identification and a separate one for photographs of participation in activities, transport and outings, giving information and also for flu vaccinations. Processes for residents unable to consent are defined and documented where relevant in the resident’s record. Staff demonstrated their understanding by being able to explain situations when this may occur. Resuscitation authorisation documentation had been updated in the files reviewed and included an example of the GP affirming when a resident was able to express their preference. All residents’ files reviewed had relevant Enduring Power of Attorney documentation in place with activation of these evident. There were no examples of advance care planning available in the files reviewed, which staff explained was the result of residents not having completed one prior to their admission to the dementia service. Staff were observed to gain consent for day to day care on an ongoing basis and of the residents’ preferences being respected. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Code, which include Advocacy Service contact details, were also displayed in the facility. Additional brochures on both the Code and separate ones on the Advocacy Services were available at reception. Family members spoken with were aware of the Advocacy Service, but felt they were the best advocate for their relative in care. Staff are aware of how to access the Advocacy Service but could not recall having to access the service in recent years, other than for advocates attending the facility for staff training sessions.  |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents are assisted to remain linked with their family and the community by attending a variety of organised outings, home visits, shopping trips, activities, and entertainment. Examples of community groups coming into the facility for social events were also provided. Professional and support services, such as the hospice and Dementia Canterbury are also available to residents and family members. The facility has unrestricted visiting hours and encourages visits from residents’ family and friends. Family members interviewed stated they feel very welcome when they visit and are comfortable in their dealings with staff. This was considered to have been especially reassuring for family members when their relative had just been admitted. A ’Support Group’ has been established for residents and family members. People take a plate and meet over a cup of tea to talk about the experience of having a relative in a residential dementia service. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints 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 available at the front foyer.The complaints register reviewed showed that four complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible. The nurse manager (NM) 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.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) when their relative was admitted. Information about the Code and the Advocacy Service is in the admission package. The Code is displayed in the hallway after entering the second set of doors of the facility. Copies of brochures on the Code, together with information on advocacy services, how to make a complaint and feedback forms are at the front entrance. The nurse manager who will continue when the service changes ownership has been in the health sector for many years and is familiar with the Code, however she will not be remaining in the position post acquisition and Heritage Lifecare Limited (HLL) will be recruiting for a replacement facility manager. HLL have a number of other aged care facilities and the management team are all aware of the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Most residents interviewed informed they were happy living at Princes Court and family members informed that from what they see, the residents receive services in a manner that has regard for their dignity, privacy, spirituality and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to personal cares. Senior staff informed that all workers are reminded to treat the residents as they would like to be treated, or how they would like a family member to be treated. Resident information is held securely and privately and verbal information to relatives was exchanged in private areas. All residents have a private room and the care plans informed that they are to be encouraged to maintain their independence by doing as much as they can for themselves. Each plan included documentation related to the resident’s abilities, personal preferences and strategies to maximise independence. Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into both their care plan and their activity/diversional therapy plan. Access to pastoral care is facilitated and an interdenominational service is held monthly.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.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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. | FA | There were no residents in the facility at the time of audit who identified as Māori. It was reported that the principles of the Treaty of Waitangi and the importance of whānau to Māori people are known to all staff with education at orientation and ongoing after that. Staff confirmed their understanding. A current Māori health plan, which was initially developed with input from cultural advisers is available. This includes recommendations for the use of the te whare tapa wha Māori model of health, as well as reminders about the principles of the Treaty of Waitangi. There is also a separate policy on the Treaty of Waitangi. Current access to resources, local cultural advisors and advice and guidance on tikanga best practice are available via staff links with the local public health unit.An example of management of a previous resident who identified as Māori was provided. There were reports of how the strong whānau connections were respected. Feedback provided from the relative following the death of the person included acknowledgement of the respect of their cultural needs.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. There is a ‘Preferred Care’ form that relatives are asked to complete for new residents either before, or at the time of admission. Residents’ personal preferences in relation to their individual culture, values, beliefs, preferences and special interests were evident in all care plans reviewed. They were also acknowledged and integrated into their activity/diversional therapy plan. Examples included night-time behaviours, previous links with clubs and institutions, preferred places to go out to, links with former workmates, regular social gatherings and any church or spiritual following. A family satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met and this supported that individual needs are being met. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Family members interviewed stated that there was no evidence of residents experiencing any type of discrimination, harassment or exploitation. The nurse manager noted there is a zero tolerance of such actions and informed that staff sign a Code of Conduct when they commence employment acknowledging this. Induction processes for all staff roles include education related to professional boundaries and expected behaviours. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, confirmed they knew about abuse and neglect and that it would not be acceptable at any level. They also stated that if they saw anything they were not comfortable about, then they would report it.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence-based policies that have been updated when required, input from external specialist services and allied health professionals. Examples of these included the hospice/palliative care team, psychogeriatrician and mental health services for older persons. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff informed that one of the things they do well at Princes Court is treat their residents with a high level of dignity and respect, which was also in the feedback from family members and was observed during the audit. Staff reported they receive management support for external education and strong encouragement to attend internally offered learning opportunities. Other examples of good practice observed during the audit included the diversity and innovative nature of the activity programme and the establishment of the support group for residents and family members, which is well attended and for which positive feedback was provided.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Family members 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 of the outcomes of regular and any urgent medical reviews. This was supported in the family contact page and progress notes of residents’ records reviewed, as well as on completed incident forms. There was also evidence of family input into the care planning process and when residents were able to contribute to this process it was apparent they had done so. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. The nurse manager and the enrolled nurse informed that interpreter services can be accessed via the District Health Board should they be required. This is also noted in the relevant policy document. Staff reported that they thought this was unlikely to be required because previous experiences have shown that the strong support from family members has precluded such a need. A section of each of the care plans reviewed conveyed information on communication and what the easiest form(s) of communication are to use when relating with the resident.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and long-term objectives and the associated operational plans. A sample of monthly reports to the owners showed adequate information to monitor performance is reported including staffing, financial performance, emerging risks and issues, complaints and audit results. The owner/business manager (BM) was onsite during the audit and is at the facility routinely two days a week.The service is managed by a NM who holds relevant qualifications and has been in the role for four months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The NM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through sector meetings and aged care seminars. The service holds contracts with Canterbury District Health Board (CDHB) for respite, rest home care - dementia. Thirty-three residents were receiving services under the contract at the time of audit.New Provider Interview February 2019:The new provider (Heritage Lifecare Ltd – HLL) is an established New Zealand aged care provider, currently operating more than 2042 beds in the sector. This proposed acquisition will add a second facility in Ashburton and one more across the country. An organisational structure document sighted detailed the reporting lines to the board currently in place (as at 30 November 2018). The transition plan is led by an experienced and well-qualified project team who are specifically focussing on the integration of the current facility into the Heritage Lifecare Ltd group. This includes provision of infrastructure support such as providing information technology capability including hardware and software. A site specific quality transition plan has been developed and this includes a roll out plan for HLL systems and processes. This is planned to occur within the first six months. The project team is working with the Princes Court Limited – Princes Court Dementia team to ensure a smooth transition of the service. It is expected that the senior team will remain in place at each facility. It is expected that existing staff, with exception of the nurse manager (HLL will be recruiting for a replacement facility manager) will transfer to the new provider. The prospective purchaser has notified the relevant District Health Board prior to the provisional audit being undertaken. |
| Standard 1.2.2: Service Management 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.  | FA | When the NM is absent, the owner or a registered nurse (RN) carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a 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.New Provider Interview February 2019:The prospective provider is not planning any staffing changes, with the exception of the nurse manager (refer criterion 1.2.1). Existing cover arrangements for the day to day operations will remain in place, with access to regional operations managers. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, wounds and behaviour. A family survey has not been completed.Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls, entered onto the electronic system but not always closed out and this requires improvement. A family satisfaction survey has not been completed in the past year. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The NM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. She is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. New Provider Interview February 2019:During the transition phase, HLL policies and procedures will be introduced. This is anticipated to be within six months of the purchase. HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes internal audits and improvement activities and projects. A site specific quality transition plan has been developed and this includes a roll out plan for HLL systems and processes. Reporting against the quality plan occurs monthly via the quality structure as monthly clinical indicator data is reported to the quality team. |
| Standard 1.2.4: Adverse Event Reporting 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.  | FA | Staff document adverse events on an incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up and entered onto the electronic system in a timely manner. Adverse event data is collated, analysed and reported to the BM weekly, but not routinely closed out (refer criterion 1.2.3.8).The NM described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of significant events made to the Ministry of Health since the previous audit. This has been resolved.New Provider Interview February 2019:There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The general manager clinical and quality interviewed was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | 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 confirmed the organisation’s policies are being consistently implemented and records are maintained.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 a three-month period and then annually. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. A contracted assessor is the assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. There are enough 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. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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. 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 on each shift has a current first aid certificate.New Provider Interview February 2019:The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the Guidelines for safe staffing level and indicators. The representative for HLL interviewed was able to confirm understanding of the required skill mix to ensure rest home dementia care residents’ needs are met. The organisation already provides the range of levels of care (geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | The resident’s name, date of birth and National Health Index (NHI) number are used on labels 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. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information being entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.A corrective action has been raised to address the need for entries in residents’ progress notes to more accurately reflect the time the activity occurred and to ensure it is consistent with current best practice and individuals’ care plans.  |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | 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 families are encouraged to visit the facility prior to admission and meet with the nurse manager. They are also provided with a package of written information about the service and the admission process. The service operates a waiting list for entry when it has full occupancy. 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, medical reviews and signed admission agreements in accordance with contractual requirements.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Discharges or transfers from Princes Court are managed in a planned and co-ordinated manner, with an escort provided if a family member is unavailable. The service uses the DHB’s ‘yellow envelope’ system, providing the required documentation and completing the associated transfer form when transferring residents to and from acute care services. Copies of such documentation were sighted in residents’ files reviewed. At the time of transition between services, for example for a person moving to a psychogeriatric service, appropriate information, including medication records and the latest interRAI assessment and a completed transfer form are provided for the ongoing management of the resident. A verbal handover is given, and Princes Court staff make themselves available to provide any additional information requested after the transfer. The nurse manager and the enrolled nurse noted there is open communication between all services, the family and with the resident as far as possible during any transfers.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine administration 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. Records sighted confirmed that all staff who administer medicines are competent to perform the function they manage, including the enrolled nurse and the registered nurses having a current syringe driver competency. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. All medications sighted were within current use by dates and medicines are stored safely in locked medicine trolleys, one in each of the two nurses’ stations that have numeric key pad locks in situ. Clinical pharmacist input is provided on request as the contracted pharmacy is in Christchurch. A local pharmacy is used for urgent and most controlled medicines. There were no controlled drugs in use on the day of audit. When required, controlled drugs are stored securely in accordance with requirements and a controlled drug register provided evidence of weekly and six-monthly stock checks and pharmacy involvement. Controlled drugs are checked by two staff for accuracy in administration. There is not currently a designated medicine fridge; however, the maintenance person advised he had been asked to get quotes for the owner to purchase one, which is a quality improvement process under way resulting from a staff meeting. This was confirmed by the owner. Medicines that require refrigeration are currently stored in a fridge in the kitchen, for which temperatures are checked daily.Not all prescribing practices meet requirements. This has been raised for corrective action alongside the need for reconciliation processes to be recorded. There were no residents who were self-administering medications in this dementia service. Medication errors are reported to the nurse manager and recorded on an accident/incident form. The designated representative of the resident is advised accordingly and depending on the resident they too are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified. Standing orders are no longer used in this facility.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food service is provided on site by an experienced cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns, rotates over a six-week timeframe and was last reviewed by a qualified dietitian in March 2017. Recommendations made by the dietitian have been implemented, which addresses part of the corrective action raised at the last audit. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines and the required forms are being completed. Food is stored according to requirements and addresses another part of the corrective action raised at the last audit. The service provider operates with an approved food safety plan and registration issued by the local district council is valid until 2 March 2019. Evidence that the invoice for the upcoming review visit has been paid was sighted. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has previously undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Copies of these are provided to the kitchen enabling personal food preferences, any special diets and modified texture requirements of residents to be accommodated in the daily meal plan. Allergies and potential consequences are clearly displayed inside the kitchen. Residents in this facility have access to food and fluids at all time and one person has an additional small evening meal, which helps to keep him settled in the evening. Family members interviewed expressed satisfaction with what they saw of the meals provided with one noting weight gain for their relative. Any significant weight loss is medically reviewed and referred to a dietitian as needed. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.2: Declining Referral/Entry To Services 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.  | FA | Relevant policy and procedures for declining referral/entry to the service are in place. The nurse manager reported that she explains the level and type of care provided at Princes Court to any person enquiring about the services. Any enquiry about entry to the service for a person who has not been assessed as requiring rest home level dementia care is redirected to the NASC agency for a referral. In the event of an inappropriate referral, the nurse manager has a conversation with the referrer and/or GP and explains the need for the potential resident to be assessed by a relevant specialist within the Older Persons’ Mental Health Services.There is a waiting list for people/family wanting to enter the facility when there is full occupancy.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On entry to the service, information is documented using validated nursing assessment tools including for pressure injury risk, nutritional requirements, risk of falling, continence and basics of weight and blood pressure. The information obtained is integrated into the initial 21-day short term care plan and then into interRAI. The sample of care plans reviewed had an integrated range of resident-related information with evidence of triggers from the interRAI assessment forming the basis of the care plans with the use of the interRAI care planning tool. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site.Comprehensive assessments are also completed to assist with the development of behaviour management plans and for the activities plans.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular the needs identified by the interRAI assessments were clearly reflected in the care plans reviewed. This is the result of the service provider using the interRAI generated care plans. All care plans reviewed were easy to follow and were consistent with the person’s goals. Service delivery records evidence service integration with progress notes, activities notes, medical and allied health professional’s 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. The lack of behaviour management plans as identified during the last audit has been addressed and is no longer an issue. Staff have undertaken relevant training. Adverse behaviour assessments are completed, and relevant interventions are sufficiently detailed to be followed through by staff. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care overall seems ‘fairly good’. Caregivers informed that care is provided as outlined in the documentation, although the enrolled nurse, or the nurse manager guides them and keeps them updated. A range of equipment and resources that reflects the needs of residents with dementia was available.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by a trained and experienced diversional therapist holding the national Certificate in Diversional Therapy, an activities coordinator and two aides. Volunteers assist at times. A social assessment and history are 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 comprehensively evaluated as part of the formal six-monthly care plan review and when a change is evident. The planned monthly activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. It is diverse and dynamic. Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included gardening, entertainment/music, exercises, craft, flower arranging, household chores games and celebrations of festivals. The activities programme is discussed with residents’ and with relatives. Family satisfaction surveys demonstrated satisfaction with the programme and that information from all feedback processes is used to improve the range of activities offered. Family members stated that there is always something occurring, and they appear happy most of the time. All residents have a detailed 24-hour activity plan and additional activities are offered at times when residents are most physically active and/or restless. For example, the activities programme also has a dedicated person between 5pm and 8pm each evening Monday to Friday and 4pm to 8pm on Saturday and Sunday. One person assists during the afternoon on Saturdays and Sundays. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. As noted in 1.2.9.1, the progress notes did not all accurately record the time some interventions were completed. If any change to a resident occurs, these are noted and reported to the registered nurse, enrolled nurse and/or the nurse manager depending on the situation. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment and as residents’ needs change. Evaluations are documented by the enrolled nurse, registered nurse or the nurse manager. Where progress is different from expected, the service responds by initiating changes to the plan of care. The diversional therapy/activity plans and tools are evaluated separately. They are detailed, personalised and described the level of participation and/or achievement the resident is demonstrating.Short-term care plans were consistently reviewed with examples being for skin tears, behaviour changes and weight loss. Progress is evaluated as clinically indicated 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. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. All felt they were listened to by staff and appropriate action was taken if they notice any change(s) in their relative. |
| 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.  | FA | Residents are supported to access referral to other health and/or disability service providers. All referrals are documented. Although the service has a ‘house doctor’, residents or their family member may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, a referral to seek specialist input is made and examples of these were evident in residents’ records. Two sets of related documentation were sighted for referrals to the older person’s health psychogeriatrician for the reassessment of two residents. Referrals are followed up by the registered or enrolled nurse or the GP. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.Other examples of referrals made that were sighted were for dental care, eye outpatients and a dietitian. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | 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. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 01 May 2019) is publicly displayed. 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.External areas are safely maintained and appropriate to the resident groups and setting. Staff confirmed they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned. Family members and residents reported they were happy with the environment.New Provider Interview February 2019:HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each facility. There are no plans for any environmental changes in the facility at this point.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes separate staff and visitor toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence.  |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | 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. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and family members reported the adequacy of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | 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, and extra small areas are available. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is undertaken on site in a spacious laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Family members interviewed reported the laundry is managed well and their relative’s clothes are returned in a timely manner.There is a small designated cleaning team who have received appropriate training, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme, and externally for effectiveness by the contracted chemical supplier. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | 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 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 11th April 2011. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 15 January 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.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 containers are located in the garage area. Emergency lighting is regularly tested.Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and families reported staff respond promptly to call bells.Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows that look out onto the well-maintained gardens. Heating is provided by electrical panel heating in residents’ rooms and heat pumps in the communal areas. Areas were comfortable and well ventilated throughout the audit (despite there being very hot days during the audit), and residents and families confirmed the facilities are maintained at an appropriate temperature. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed by an external expert with input from this service provider. The infection control programme and manual are reviewed annually. A senior caregiver, who has an interest in the topic, is the infection control coordinator and works under the nurse manager/registered nurse. The role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the nurse manager, and tabled at the quality and risk management meeting, as well as at wider staff meetings. It was reported that signs advising of the risk of entry are placed at the front door when an outbreak occurs. Family members are informed by telephone if an outbreak occurs. During the winter influenza season signs request that people not enter the facility if they have been unwell in the past 48 hours. 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 and the nurse manager confirmed this but also advised that staff are sent home if they do arrive unwell or become unwell during a shift. |
| Standard 3.2: Implementing the infection control programmeThere 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 coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for more than three years. Training records sighted confirm the additional specialist training has been undertaken and the enrolled nurse and the nurse manager confirmed that the registered and enrolled nurse oversee the role. The GP provides additional information as needed, well-established local networks with the infection control team at the DHB are available and expert advice from a community microbiologist can be accessed. The coordinator and registered nurses have access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.The infection prevention and control coordinator was unable to be interviewed during this audit.  |
| Standard 3.3: Policies and proceduresDocumented 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 reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2018 and include appropriate referencing. Heritage Lifecare infection prevention and control policies and procedures will be introduced if the sale proceeds.Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | 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 at orientation and ongoing education sessions. A key focus is on handwashing and handwashing competencies are completed annually with the last being November 2018. The content of all training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Education with residents is generally on a one-to-one basis and staff informed that because of this being a dementia service this needs to be at the time of the infection. Examples provided were reminders to residents to cover their mouth when coughing and sneezing, handwashing, using hand sanitiser and wipes and ensuring they have enough to drink.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | 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 on an infection control data sheet and details are then transferred into an electronic monitoring system. The infection control coordinator ensures all reported infections are reviewed. 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. Graphs are produced that identify trends for the current year, and this is reported to the nurse manager and the quality and risk management committee. Surveillance results are shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff. Learnings from the identified patterns and corrective action/quality improvement processes are included in handovers and staff education sessions.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her role and responsibilities. On the day of audit, one resident was identified using two restraints (a lap belt and personal restraint). No residents were using enablers. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.New Provider Interview February 2019:HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for use of enablers. These policies are implemented across the group and a small number of restraint devices are approved for use following assessment. The prospective provider is experienced in the requirements of the standard, as it pertains to aged residential care.  |
| Standard 2.2.1: Restraint approval and processesServices maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.  | FA | The restraint approval group, made up of the NM and the GP, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents’ files and interviews with the NM that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed, however meeting minutes do not always include restraints in use (refer criterion 2.2.3.4)Evidence of family/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care. |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | 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 NM interviewed described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident’s safety and security. Completed assessments were sighted in the records of residents who were using a restraint. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | PA Moderate | The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (e.g., the use of sensor mats, low beds and trackers). When restraints are in use, frequent monitoring occurs to ensure the resident remains safe, however not all restraints are documented. Records of monitoring had the necessary details, but not all the times restraint was used. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint, but also needs to include all type of restraint (table in front of chair). There was sufficient information to provide an auditable record. Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. However, staff spoken to did not all clearly understand what type of restraint were in use and the monitoring required. |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | Review of residents’ files with approved restraint showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations with the GP but not at quality meetings (refer criterion 2.2.3.4). Family member interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.  |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The NM and GP undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. This was evident in the residents’ files reviewed. The quality meeting has not identified the restraints currently in use (refer criterion 2.3.3.4). Any changes to policies, guidelines, education and processes are implemented if indicated during policy review.  |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.8A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The NM collects data from adverse events and enters these each day onto an electronic system and a corrective action is generated. Those reviewed show that corrective actions have been recommended and a plan put in place. However, these are not routinely closed out within a specified timeframe. | An electronic system is implemented to collect and collate data from adverse events and a corrective action is generated. Twenty corrective action entries have been recorded since May 2018 with strategies identified to minimise the risks. These are reported routinely at the quality and staff meetings and a discussion on the implemented strategies, but most have not been closed off in the electronic system.  | Corrective action plans are closed off in a timely manner.180 days |
| Criterion 1.2.9.1Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting. | PA Low | Staff on each shift are required to enter relevant information into the progress notes of each resident’s personal file. Overall, this is occurring; however, there were multiple examples of night shift staff writing into progress notes between 3am and 4am; three to four hours prior to the end of the shift. The remainder of some of these night shift records were then written up by morning duty staff between approximately 11am and 1pm stating for example that the person’s activities of daily living had been completed by the night staff. This is not only an early timeframe for so many residents to be having their activities of daily living completed; but one person’s file clearly stated in the assessment that they only wake at 7am despite the progress notes stating most days that they are showered before this.  | There were examples of residents’ records not being entered in a timely manner with morning shift staff writing in residents’ progress notes that the night shift had completed the person’s activities of daily living.  | Information is entered into the residents’ records on the shift the interventions were carried out and the record reflects actions are occurring at an appropriate time for the individual and for the service type.90 days |
| Criterion 1.3.12.6Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | Prescribed medicines are entered onto paper copy medicine records by the prescribing practitioner. Internal audits have identified issues in relation to medicine records not all meeting requirements and staff reported efforts they have been made with local GPs to address the shortcomings. However, on the day of audit four of the 14 records did not have a date of discontinuation of medicines and/or timeframe for short course medicines. There were five faxed copies of medicine records with one dating back to August 2018 and another October 2018, which have since had reviews placed on them. Four medicine records did not state the use of ‘PRN’ (as required) medicines, with some others being illegible and four did not state the allergy status of the resident. The review date was either not noted or was overdue (back to August, October and early November 2018) on five of the records. Medicines brought into the facility by relatives or following a hospital admission and new packages are reportedly being checked for accuracy to ensure the prescription matches the medicines and vice versa; however, there is no recording system of these reconciliation and checking processes.  | Medicine records are not consistently meeting the requirements of legislation and service sector guidelines. For example:- Faxed copies of medicine records from as far back as six months ago have not been replaced by the original version- There were examples of short-term medicines without a timeframe or date of discontinuation and of discontinued medicines crossed out but without a date- Not all prescriptions of PRN medicines include the intended use, or the addition was illegible- Five medication records did not have a review date on them; although two of these had had at least one alteration meantime- Not all medication records state the resident’s allergy status- There is no documentation process to demonstrate medicine reconciliation is occurring | All medicine management records are recorded in a manner that complies with legislation and service sector guidelines.90 days |
| Criterion 2.2.3.4Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:(a) Details of the reasons for initiating the restraint, including the desired outcome;(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;(c) Details of any advocacy/support offered, provided or facilitated;(d) The outcome of the restraint;(e) Any injury to any person as a result of the use of restraint;(f) Observations and monitoring of the consumer during the restraint;(g) Comments resulting from the evaluation of the restraint. | PA Moderate | There is a restraint monitoring form for staff to complete. The current form includes five episodes of restraint (a lap belt) over the past two months and a daily entry for personal restraint for one resident, with a tick box for each day. Staff reported that personal restraint for this resident is used several times during the day while undertaking personal care tasks, however each restraint episode is not being recorded. The auditor observed one resident sitting with a table restricting movement (this was outside mealtimes), and it was indicated on the resident’s care plan this was to be left there. This has not been identified or approved as a restraint, and the resident may or may not have the capacity to remove it. Staff were unclear about all types of restraints in use and the required reporting processes for these, or what an enabler is.Quality meeting minutes included restraint, however those reviewed for 16 January 2019 state ‘no restraints in use’, when one resident’s restraints have been in place since December 2018. | One resident with a table restricting movement while sitting in her chair, did not have this identified as a restraint. Personal restraint has been identified as appropriate for one resident, but each episode of restraint is not recorded with detail as required in the standard.Quality meeting minutes do not include restraints in use.Not all staff are clear on restraints in use and reporting and monitoring processes for these, or what an enabler is.  | All episodes of restraint are approved, documented, monitored and reported. All staff are trained in all aspects of restraint minimisation and evidence of restraints in use is documented in the quality meeting minutes.90 days |

# 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.

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End of the report.