

Heritage Lifecare (BPA) Limited - Broadview Rest Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare (BPA) Limited
Premises audited:	Broadview Rest Home & Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 22 January 2019 End date: 23 January 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	65



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

Broadview Rest Home and Hospital provides rest home, hospital, dementia, mental health and psychogeriatric care for up to 87 residents. The service is operated by Heritage Lifecare (BPA) Limited and managed by a facility manager and a clinical services manager. Residents and families interviewed 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 Whanganui District Health Board (WDHB). The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, staff, contracted health providers, two general practitioners and a consultant psychiatrist. A reconfiguration of beds/space has occurred by converting two lounges into two medical/geriatric bedrooms increasing the number of beds from 85 to 87. These changes were also reviewed.

The audit has resulted in no areas identified as requiring 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, and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

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.

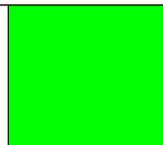
Service provision is safe. The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

Residents in Kauri, the mental health ward, actively participate in their care planning and records evidenced they had signed accordingly. Cultural and spiritual beliefs are incorporated as appropriate. Families are supported and encouraged to visit, with effort put into maintaining family involvement in treatment planning, lifestyle choices and activities. Residents can participate in activities with other parts of the organisation, as well as have involvement in community activities. Residents expressed appreciation of the respect for individual spiritual beliefs and the variety of activities.

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.

The business and quality and risk management plans include the scope, direction, objectives and values 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 continuous 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 provision and were current and reviewed on a regular basis.

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

Staff working in the mental health, dementia and psychogeriatric services have received the required training. There is minimal consumer participation in the mental health service due to the nature of this service. Family/whanau participation is encouraged and a consumer advocate for all services including mental health is available.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained using integrated electronic and hard copy files.

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 and Specialist services, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, enough and relevant information is provided to the potential resident/family to facilitate the admission. When service entry is declined, a meeting is held with the potential resident and family to explain the reason. Other options will be suggested where possible. It is also communicated in writing. This information is documented and kept on file in the facility.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and handover reports guide continuity of care. Staff are qualified, experienced and competent.

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. Risk assessment, early warning signs and relapse prevention are assessed on entry and six monthly, or as required. There is also a variety of other assessments for use as appropriate, for example for falls, pain, challenging behaviour, oral health, pressure risk, continence. 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.

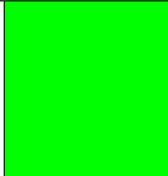
The planned activity programme is overseen by a diversional therapist and two activity assistants. The programme provides all residents with a variety of individual and group activities to choose from and maintains their links with the community. In Kauri, the programme is recovery focussed. The younger disabled residents have individual recreational plans to meet their needs. Each resident has a copy in their bedroom as well as in the lounge area. A facility van is available for outings.

Residents have access to other health and disability providers and any referrals or interactions are documented on file. Residents are transferred or discharged following consultation and involvement of other relevant care providers, and timely completion of the discharge/transfer management plan.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. A medication manual is incorporated into the policy which details all aspects of medicine management, administration, reconciliation and disposal. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. A nutritional profile is completed on entry. Residents and family commented that there is a good choice of menu, the food was tasty and hot when delivered, that drinks are available at any time and special requirements are catered for. The kitchen was well organised, clean and meets food safety standards. Residents verified overall 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 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 activated. 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 service has a comprehensive system ensuring safe restraint practice which complies with the required standards. Staff know and follow the current policy which encompasses philosophy, responsibilities, forms of restraint and enablers and the process (from assessment, approval, implementation, monitoring, evaluation and review). Use of enablers is voluntary and used for the safety of the resident. Restraints and enablers were in use at the time of audit and met the standard and policy requirements. The organisation is actively working to minimise restraint.

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 experienced and appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. 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, with data analysed, trended, benchmarked 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	52	0	0	0	0	0
Criteria	0	115	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>Broadview Rest Home and Hospital (Broadview) has policies, procedures and processes in place 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 demonstrated respectful communication that encouraged independence, provided options, facilitated informed choice and maintained dignity and privacy. Training in the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. Staff showed understanding of the various cultural and spiritual beliefs held by residents.</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</p>	FA	<p>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 including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>All residents in the dementia, psychogeriatric and the secure unit had activated EPOAs, in addition to specialist</p>

<p>give informed consent.</p>		<p>assessments supporting placement in secure units.</p> <p>Staff were observed to gain consent for day to day care and activities on an ongoing basis.</p> <p>There is a specific consent form for proposed treatments or procedures. Completed forms were evident in files reviewed as were advance directives.</p> <p>The service does not store or use body parts or bodily substances.</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>	<p>FA</p>	<p>During the admission process, residents and families/whanau are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Code were also displayed in the facility. Additional brochures on the Code and advocacy service were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>The facility has two residents' advocates who run the residents' meeting. Interviews with one of the advocates verified managements prompt response to any areas of concern. Residents' meetings include reminders from the advocates of their availability to assist residents if needed, and the accessibility of the advocacy service if needed.</p> <p>Staff were aware of how to access the Advocacy Service.</p> <p>Kauri has the advocacy services available from Broadview's wider service. There is also a Kauri-specific person. The names and phone numbers were sighted in the unit as well as in the residents' handbook, given on entry. Residents and family spoken to were aware of the availability of advocacy. Staff were also aware of the service and how to make contact for a resident, if requested. Over the last twelve months, the service has made attempts to contact Balance, the local consumer group but as yet has had no reply (emails sighted). The District Inspector contact was sighted on the wall in the living areas. A family representative from Mental Health and Wellbeing Support, a local family service, attends the quarterly resident and family meeting (minutes sighted).</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>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p> <p>Residents are supported on outings by a support person.</p> <p>Kauri has a policy on family participation and contact. There is evidence of family involvement in files and from comment by residents and family interviewed. To encourage ongoing contact with family and friends, visiting is unrestricted unless stipulated by a resident as detailed in the visitor and support person policy. Family members</p>

		<p>commented they felt welcome and were happy to approach staff with any concerns.</p> <p>The diversional therapist is very focussed on residents maintaining their skills and contacts in the community. The monthly planner on display in the living area of the unit and in resident's bedrooms, evidences a number of organised outings in the community, with other parts of Broadview or people from the community coming into Kauri. A Maori woman with a guitar held a singalong in English and Te Reo Maori, whilst the audit occurred. There is a good range of activities residents can choose from, or individual activities for those that prefer their personal activities.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints and concerns policy meets 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. Compliments received are kept in a separate folder.</p> <p>The complaints register reviewed showed that six complaints have been received this year and that actions taken, through to an agreed resolution are documented and completed within the timeframes required. Action plans showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. 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>	FA	<p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas around the facility. Brochures on the Code, information on advocacy services, how to make a complaint and feedback forms were available in the entrance foyer.</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</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussions with families, the GP and specialist service providers. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each lifestyle care plan included</p>

<p>for their dignity, privacy, and independence.</p>		<p>documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</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>	<p>FA</p>	<p>There were six residents in Broadview at the time of audit who identified as Māori. Evidence, including resident interviews, verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed at organisational level with input from cultural advisers. A local kaumatua provides advice and assistance if needed and has been used in the past to bridge cultural expectations by some families/whanau whilst considering the needs and comfort of all residents.</p> <p>At the time of audit there are no residents in Kauri who identify as Maori; however, there are a number of employees who identify as Maori and staff described links with the local marae and the district health board (DHB) to access cultural support should it be required. One staff interviewed was able to speak te reo Maori and also reported Maori and tamariki coming into the ward to entertain with singing and dancing. This was observed on the day of the audit. The staff person acknowledged the different considerations should there be a Maori resident in Kauri, particularly the involvement of whanau and tikanga practices. The clinical services manager (CSM) reports the service has connections with te Oranganui Hauora, the local kaupapa Maori service.</p>
<p>Standard 1.1.5: Recognition Of Pacific Values And Beliefs</p> <p>Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>No current residents were of Pacific ethnicity, however staff noted the Pacific People's Health Policy (sighted) and described how they could provide service to ensure cultural beliefs and practices are upheld, when required. For example, having the chaplain include the person in his fortnightly visit, attending church, involving family and acknowledging healing practices. There are staff employed at Broadview of Pacifica descent who can assist and also the local Pacifica service, 'Born and Raised Pasifika', provide advice and support to the service when required. They also provide music and dance entertainment on occasion.</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>	<p>FA</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 special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. Family and staff interviewed verified staff of similar cultures to residents assisted when interpreter services were required. The specific food likes of one resident was met and supplied by the family. The kitchen stored and prepared the food as per the family's instructions.</p> <p>Staff interviewed showed an understanding of diversity. They noted the number of nationalities working at Broadview that they can utilise to provide culturally appropriate service. Residents reported being asked about their ethnic identity. Residents commented that their preferences are attended to. Family interviewed reported being consulted regarding their family member's beliefs and interests.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) and visiting psychiatrist also expressed satisfaction with the standard of services provided to residents of Broadview.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. 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, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> <p>Staff interviewed showed an understanding of discrimination and professional boundaries. There is mandatory annual training on discrimination, abuse, neglect and professional boundaries for all staff. Residents and family interviewed stated they felt this is a safe service and had not ever witnessed nor experienced any staff behaviour that could be constituted as discriminatory, abusive, neglectful or inappropriate. Residents reported staff are supportive, helpful and kind. Should residents refuse any aspect of treatment, staff reported they would still be able to access all support and other treatment. There were no instances cited or recorded where this has occurred nor any indication this would not be the case based on staff/resident interaction.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, community dieticians, and mental health services for older persons. Staff are well supported in training to enable them to provide the specialist services required. The GP and the psychiatrist confirmed the service sought prompt and appropriate medical intervention when required and were responsive to</p>

<p>appropriate standard.</p>		<p>medical requests. The wound care nurse was complimentary of the improvement in wound care management over the past year.</p> <p>Within the Kauri area, all staff working in the specialist care areas had appropriate training to provide the specialised services residents required. Staff reported they receive management support for ongoing education and to access professional networks and on-line learning portals, to support contemporary good practice.</p> <p>The service promotes good practice through its policies guiding service delivery, comprehensive documentation and evidence-based training. Best practice is maintained by staff education and from the close relationship with health professionals, for example, the Consultant Psychiatrist, GP, District health Board (DHB) key workers and culturally specific community groups. The consultant and GP interviewed acknowledged the quality of the level of care and sound practice in Kauri.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents, EPOA and family/whanau members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family/EPOA input into the care planning process and regular multidisciplinary reviews. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via Age Concern, Citizen's Advice Bureau, the local court or the Whanganui District Health Board (WDHB) if required. Several staff members were able to support residents, where English was their second language and interpreter services were rarely required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans which are reviewed annually outline the purpose, values, scope, direction and objectives of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of weekly and monthly reports to the support office showed adequate information to monitor performance is reported. The facility manager (FM) reports weekly to HLL about occupancy, general comments on movements, health and safety and compliance issues (incidents and accidents), new risks identified, and any outstanding issues. The national quality and compliance manager identifies and transfers risk to the organisation's risk register and/or updates the register. There is a weekly operations meeting to review the weekly reports and discuss any issues.</p> <p>The clinical services manager (CSM) reports on clinical indicators and the interRAI assessments. Based on these reports a spread sheet with graphs collated at HLL support office and the national quality and compliance team prepare a compliance report to the general manager (GM) the chief executive officer (CEO) and the board. The reporting process is documented in the quality and risk management plan to guide staff.</p>

		<p>The service is managed by a facility manager who holds relevant qualifications and has been at the facility for 11 years. Prior to taking over this role the FM was the clinical nurse manager for five years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through relevant courses and events related to mental health and aged care and other topics of interest.</p> <p>The service holds contracts with the DHB for aged related care, aged residential assessment, long term care support – chronic health conditions – hospital, aged residential hospital specialised service, intermediate care, hospital and mental health recovery and long term support chronic health conditions (residential). On the first day of the audit there were sixty five (65) residents. Eleven (11) residents were receiving rest home level care, hospital (23), psychogeriatric (9), mental health (9), dementia (13), and younger persons (under 65 years) with a disability (YPD) (5) (this includes two residents in mental health and three receiving hospital level care).</p> <p>The reconfiguration to change two small lounges to two hospital medical/geriatric bedrooms increasing the total beds from 85 to 87 was completed. These rooms are used for acute assessments of residents from the community who may require acute short term care, stabilisation or further assessment for short or long term care. The rooms are prepared in readiness.</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 facility manager is absent, the clinical services manager carries out all the required duties under delegated authority. The clinical services manager has worked at the facility for ten years and has been the clinical nurse manager for five years. During absences of key staff, the clinical management is overseen by a senior registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. The senior registered nurse is fully supported from personnel for HLL support office.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, regular satisfaction surveys, monitoring of outcomes, clinical incidents including infections and restraint minimisation and safe practice. The internal audit schedule has been totally reviewed for 2019.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality/staff meetings. Staff reported their involvement in quality and risk management activities through audit activities. Relative corrective actions are developed and implemented to</p>

<p>risk management system that reflects continuous quality improvement principles.</p>		<p>address any shortfalls. Regular resident and family meetings are held two monthly with the last meeting being held on the 16 January 2019. The meeting is facilitated by the designated resident advocate. Annual resident and family satisfaction surveys are completed annually in October each year. The surveys are managed and sent out to residents and families by support office staff. When the information received is analysed a summary of outcomes is sent to the facility manager who provides feed-back to residents and families. Any areas of improvement are acknowledged and included in the quality improvement plan for the service. Most feedback reviewed was positive and included the change of ownership 04 April 2018 and the transitioning period following the purchase by HLL.</p> <p>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 system is managed by the quality and compliance team at the support office. Any revised policies are sent out for consultation. When signed off by the general manager (GM), the policy is sent electronically to the service providers for implementation.</p> <p>The FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The FM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Training is provided to all staff annually on the quality and risk management system requirements. Each service has their own risk register.</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. A sample of hard copy incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. All incidents are also logged into the electronic system. Adverse event data is collated, analysed and reported to the RN or clinical services manager on duty before the end of the shift on which they occur. The definition of 'serious' is documented in the risk matrix in the quality plan. Guidelines are available to guide staff with useful information on the response to different types of events, including falls, abuse, infections, damage to property/equipment and medications, security and safety. The clinical services manager collates the information, analyses and reports outcomes and trends to the quality and compliance staff at support office. Information, such as trends (eg, falls, pressure injuries, skin tears, weight loss, bruising, behaviours, infection control and medication errors), is fed back to staff at the quality/staff meetings held three monthly.</p> <p>The clinical services manager described essential notification reporting requirements, including for pressure injuries. There have been two Section 31 notices completed for pressure injuries since the previous audit. A copy is retained by the FM for verification.</p>

<p>Standard 1.2.6: Family/Whānau Participation</p> <p>Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.</p>	<p>FA</p>	<p>There is a family/whanau participation and contact policy in place. A family/whanau group/committee is being established and this was outlined in a management interview and also documented. Satisfaction surveys are completed by family/whanau six monthly. All family/whanau interviewed reported being fully involved in the service and their feedback appreciated.</p> <p>There is a family/whanau support from a staff member from Mental Health and Wellbeing Support and they were interviewed on the day of the audit. Their organisation supports family/whanau of mental health consumers. A family/whanau member of one resident in the greater Broadview complex acts as advocate for the residents in the mental health ward.</p> <p>Family/whanau are represented on both the board and the executive management.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>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 confirmed the organisation's policies are being consistently implemented and records are well 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 a three month period and annually. Records reviewed demonstrated completion of the required training and annual performance appraisals.</p> <p>Continuing education is planned on an annual basis including all mandatory training requirements. Caregivers have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. All staff who work in the dementia service and psychogeriatric services have either completed or are enrolled in the required education. Additional education is provided to staff for managing residents with mental and physical disabilities. The facility manager and a senior caregiver are the trained Assessors for NZQA qualifications for the service. The clinical services manager and staff educator (Qualified Social Worker), facilitate and implement internal education. There are fourteen (14) registered nurses inclusive of the FM and the CSM. Seven registered nurses are competent to perform the interRAI assessments and re-assessments.</p> <p>There is adequate staff available to cover the reconfiguration of the two DHB contracted assessment beds when occupied by residents acutely admitted to this service. The consultant psychiatrist interviewed provided positive feed-back on the availability of this aspect of the service and the availability of these beds if and when required.</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 across all services provided. The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster between the FM and CSM is in place with staff reporting that good access to advice is readily available when needed.</p> <p>Residents and family reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this except for one family member interviewed in relation to the mental health service who stated that there was not enough staff. Observation of a four week roster cycle 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 and there is 24 hour/seven days a week RN coverage in the hospital.</p> <p>There are three activities staff one of whom is a diversional therapist. The activities programme is spread across all services. Group and one on one activities are provided in the rest home, hospital and mental health and psychogeriatric services, both secure services. Activities are covered daily 2.30 pm to 4 pm in the dementia service by one of the activities co-ordinators and activities are planned to cover the twenty-hour period. Resources are available that meet the needs of the individual residents.</p> <p>There are sufficient staffing to cover the two designated DHB contracted assessment beds if and when residents are admitted.</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 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, psychiatrist 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 while the resident remains at Broadview, then offsite in a secure document storage facility. Records are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</p> <p>Records will be maintained if and when residents are admitted to the two DHB contracted assessment beds.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>Residents enter Broadview when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service, and additional specialist approvals provided for residents</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>to access the secure service areas provided. Prospective residents and/or their families are encouraged where possible to visit the facility prior to admission and meet with the facility manager (FM) or the clinical services manager (CSM). They are also provided with written information about the service and the admission process. The service is the only provider of psychogeriatric and long-term mental health services in the region.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p> <p>All Kauri residents are screened for entry by the consultant psychiatrist who discusses the referral with the FM and CNM, with reference to the resident screening and selection policy (sighted). Policy states the decision for admission is to be made within 48 hours in respect of the potential resident and family. The major deciding factor is risk management. To be eligible for entry, residents must have a community treatment order (CTO). All those in Kauri at the time of audit had been accepted within the timeframe, had current CTOs sighted in their files, and critical point assessments (the initial risk assessment) were complete. All were signed by residents. Family participation was noted and signed where relevant. If appropriate prior to entry, residents and family visit the unit, once or twice, meet the FM and/or CSM. They are provided with a welcome pack and additional written information as pertains to the resident. The resident's key worker may also join them.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses WDHB documentation in addition to the services transfer documents, 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 and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</p> <p>In Kauri, transfers, exit or discharges are discussed with the resident and family and are planned and documented. The process may be divided into stages to assist the resident coping with the change. A plan is formulated and a transfer/discharge form completed when transfer is imminent. This documents the reason, the resident/ family concerns, comprehensive mental and physical assessment, activities of daily living, any restraint history, night behaviour and any aids required as well as current assessment of risk, current treatment and care plan. There were no transfers or discharges occurring at the time of audit.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system (Medi-map) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and</p>

<p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>responsibilities related to each stage of medicine management. All staff who administer medicines were competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription and stored securely. All medications sighted were within current use by dates. Any medicine to be disposed of is returned to the pharmacy and recorded accordingly. The pharmacist completes a six month review and additional input is provided 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 and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this can be managed in a safe manner if required.</p> <p>Medication errors are reported to the RN and CNM and recorded on an accident/incident form. 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>Standing orders are not used.</p> <p>In Kauri, the lunchtime medication round was observed on the day of audit when a second year nursing student was administering the round, with RN oversight. The student was wearing a nylon safety vest advising she was administering medication and not to be disturbed. The RN reconciles medication administered after each round and fortnightly for the stock. Residents and family report they have been educated about the various medications and informed of any changes in medication, or any new medical interventions. For the latter, specific treatment consent forms were evidenced in records reviewed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids</p>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and had been developed by a dietician in November 2018.</p> <p>The service has a food control plan in place, which was registered with the Whanganui District Council July-2018. A verification audit of the plan was undertaken 14 August 2018, with no corrective actions required.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>The residents in the psychogeriatric and secure units have access to food at any time. Each unit has a kitchenette that enables staff to provide twenty-four-hour access to a range of food and fluids. Food is available 24 hours a day for residents admitted to the two acute assessment rooms and this has had no impact on the current food service provided.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received by Broadview, but the prospective resident does not meet the entry criteria, have the required legal documents, or there is currently no vacancy, the FM contacts the local NASC agency to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p> <p>In Kauri, referrals are rarely declined. However, should there not be a vacancy, or entry criteria not met, then a meeting is arranged with the prospective resident and family to discuss this and offer any options in conjunction with advising NASC. This is also communicated in writing and documented on file and kept in the archive cupboard.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	<p>FA</p>	<p>On admission, residents of Broadview are initially assessed using a range nursing assessment tools, such as a pain scale, falls risk, skin integrity, behaviour, nutritional screening and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing</p>

gathered and recorded in a timely manner.		<p>conditions require.</p> <p>In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents had current interRAI assessments completed by one of seven trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p> <p>Assessment of Kauri residents is timely, comprehensive and ongoing. Residents and/or family participate and sign accordingly (sighted in every file). Assessment forms the basis of care plans and files reviewed evidenced a wide range of needs are assessed, including cultural and spiritual assessment. At the time of audit there were no residents identifying as Maori or of any other ethnicity. The critical point assessment is the initial document completed on entry. This is a comprehensive risk assessment. There are several other specific assessments if required, for example, continence, falls and oral health. All of the nine files reviewed have early warning signs and relapse prevention plans documented and signed by the resident.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>All files reviewed in Kauri provided evidence of regular, ongoing planning centred on the individual resident. They are very specific about the support required, the outcome expected and cover a wide range of assessed areas. Any changes are documented and plans modified. Short term care plans were evident in some files, developed in response to an arising problem. Should the issue remain then the short term plan is incorporated into the care plan. Early warning signs and relapse prevention planning are documented and relevant to the individual. These are amended if necessary and reviewed six monthly. They are consistent with the individual's goal and care. Resident, staff and family interviews noted residents' and family participation in planning which was substantiated by signed planning documents. Plans are integrated with InterRAI, medical and allied input, podiatry, diversional therapy notes, and progress notes all clearly written, dated and signed identifying the staff person and their designation.</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 provision of care to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision.</p> <p>The attention to managing episodes of behaviours that challenge was well documented and observed in the secure and psychogeriatric units. The use of de-escalation and diversion was evident as an ongoing strategy in both areas, to minimise the opportunity for behaviours to escalate.</p> <p>The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> <p>Kauri residents receive appropriate services consistent with their assessed needs and outcomes as evidenced by interviews, documentation review and observation. Care is the least restrictive possible and staff work collaboratively with other agencies and the CMHT to promote mental health and wellbeing, prevent relapse, reduce stigma and minimise the impact of mental illness on the resident and their family.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by a trained diversional therapist, who is also a qualified mental health carer, and two activities assistants. Activities are provided by activities staff six days a week. On Sunday a range of activities are made available for residents, staff and family to access.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. An activities plan is developed for each resident. A twenty-four-hour activities plan is developed for residents in the psychogeriatric and secure unit. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>Activities are provided in each area, by one of the activities staff. All residents can attend in each area, however the programme provided in the mental health unit is solely for the attendance by those residents. The planned monthly activities programme for each area of the facility, matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered.</p> <p>Van outings for each client group occur on a weekly basis. Residents under the age of sixty-five years, are enabled opportunities to participate in community activities, often with a support person. The activities programme is discussed at the minuted residents and family meetings and indicated residents' input is sought and responded</p>

		<p>to. Residents and family members interviewed confirmed they find the programme meets their needs.</p> <p>Kauri has a fulltime, registered diversional therapist who develops the activity programme based on the age, cognitive ability and mental status of the residents. The therapist stressed the programme is recovery focussed and strengths based which was evident reading the programme planner. Social activities assessment is included in care planning (sighted in all files) and reviewed in the six monthly MDT meeting. The programme is seven days a week. It takes into account the care plan goals and is responsive to the residents' interests. It can be tailored to the individual or group. The monthly planner was seen on the walls in the living area and also in each resident's bedroom. There is an activities folder in the staff office which details activities, the objective and the benefits of each. The programme is varied. It includes cognitive and physical exercise, entertainment, music, religion, outings. It is very inclusive, sharing activities with the rest of Broadview, for example, bowls, and also the community, for example, church. There are also game, books, music available in the living area and residents have easy access into the closed garden. One of the successful innovations has been pet therapy with canine friends visiting. Residents were observed enjoying board games with staff at the time of audit and there was a visiting guest entertainer, a Maori woman playing the guitar and singing in te reo Maori and English. Residents and family interviewed confirmed they enjoyed the different activities. The family person interviewed noted she would prefer more participation by her brother however his choice of more individual time is respected.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care in the hospital and rest home is evaluated each shift and reported in the progress notes. Resident care and behaviour management in the psychogeriatric and secure units, is continually being evaluated and reported in the progress notes, and on behaviour monitoring charts. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections, pain, weight loss and progress 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. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>In Kauri, staff evaluate residents on a daily basis recorded in the daily records and progress notes (sighted). Formal reviews are completed six monthly by the MDT and recorded in files and any changes noted in care plans and signed by the resident and/or family (sighted). However, plans are also responsive to any changes in the resident's mental and/or physical status. Such changes may be managed by developing short term care plans, for example, for wound care or urinary tract infections, or by altering the long term care plans, for example attending (or no longer attending) specific activities in the community. GP reviews are three monthly and CPR status reviewed by the GP six monthly. All were evident in each of the nine files reviewed.</p>

		Clinicians and the consultant psychiatrist use a range of outcome measures used to evaluate resident's mental health status, for example, the mood scale, sadness depression assessment chart and Montreal cognitive assessment tool.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. 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>The psychiatrist from the mental health service visits the service twice weekly and is accessible by phone during normal working hours and by text after hours. After-hours access to emergency mental health services is available.</p> <p>Residents in Kauri are advised of options for other relevant health and disability providers or community agencies and supported to access these. Such options, and the resident and/or family responses were recorded on file. There is a choice of GP although 98% of residents utilise the visiting GP. Copies of referrals to other providers were sighted on files, and residents and family spoke of options provided.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material data sheets were available where chemicals are stored and staff interviewed knew what to do should there be a chemical spill/event.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. Supplies are accessible to staff working in all services as well as for the maintenance person and contractors should this be required.</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 22 June 2019 is publicly displayed. All buildings, plant and equipment comply with legislative requirements.</p> <p>Appropriate systems are in place to ensure the resident's 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. An inventory is maintained of all equipment. The boiler is checked on a regular basis by the preferred contracted plumber and records are maintained. The maintenance person has been employed at the facility for eight years. The maintenance planner was reviewed. Monthly maintenance is documented to be completed and signed off as completed. The environment was hazard free, residents were safe and independence is promoted. There are three standing hoists and two sling hoists for transferring residents safely.</p> <p>External areas are safely maintained and appropriate to the resident groups and setting. The external area has been upgraded since the previous audit. Shade and seating is available. There is a level pathway around the facility and a water feature for residents to enjoy. The dementia service has an outside level area with raised gardens and outside furniture. Shade is available. The environment is safe and appropriately fenced (fencing was replaced since the previous audit). The YPD residents in the hospital and mental health care settings have adequate space to walk around as needed and if any equipment is required this is accessible.</p> <p>The reconfiguration of changing two small lounges into two bedrooms are located in Victoria hospital wing were reviewed, and the rooms are set up appropriately. The rooms are furnished, comfortable and fit for purpose.</p> <p>Residents and staff confirmed they knew the processes they should follow if any repairs or maintenance were required, that any requests are appropriately actioned and that they are happy with the environment. Families confirmed residents use all areas of the facility available and accessible to them.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility including the mental health and the psychogeriatric services. There is one room in the psychogeriatric service with an ensuite in case an isolation room is required. There are hand basins in the individual resident's rooms in the psychogeriatric service. There are no hand basins in the individual rooms in the dementia service. There are two separate communal shower/toilet blocks in the dementia service. The mental health service has one room with ensuites and separate toilet and shower amenities were sighted for residents. There is provision for staff to wash their hands in the sluice, treatment rooms and recessed areas in the hallway as needed. There are separate toilets in close proximity to residents' rooms in the psychogeriatric service.</p> <p>The rest home resident individual rooms all have ensuites consisting of a toilet and hand basin. The hospital wing has single and shared ensuites with separate communal shower, a shower/trolley room and separate toilets for residents with disability access. Appropriately secured and approved handrails are provided in the toilet/shower</p>

with personal hygiene requirements.		areas, and other equipment/accessories are available to promote resident independence.
<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. The psychogeriatric and mental health services have little furniture as this is regularly dismantled and/or destroyed by the residents. A replacement plan is in place.</p> <p>There is room in the rest home and hospital services to store mobility aids, wheel chairs and mobility scooters. Mobility aids are available as needed for individual residents in the other services to encourage independence and mobility. 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 in all service areas 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 settings and to meet the residents' individual needs. There is a piano in the dementia service lounge and a separate whanau room. Activities are provided in all services in the lounge/dining areas or one on one in the individual resident's room if required. There is a separate hair salon and the hairdresser visits regularly on a Tuesday. There is a lift which is available between the main two floors. This provides access to downstairs where the mental health and psychogeriatric services are situated. The lift can fit a hospital bed if needed for a transfer situation or other reasons.</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</p>	FA	<p>Laundry is undertaken in a laundry on site. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. The laundry staff member interviewed has been employed in this role for seven years. A linen-shute is available between the two floors and linen goes directly into the large collecting basket in the laundry. There are two commercial washing machines and two commercial dryers. One additional washing machine is available for the residents' personal clothing. Residents and family interviewed reported the laundry is managed well and clothes are returned in a timely manner.</p> <p>The cleaning staff and laundry staff have completed relevant training for their respective roles and for handling any chemicals required. The staff interviewed feel well supported in their roles. Care staff assist in both the laundry and/or the cleaning of the facility as needed. The chemicals are managed by the contracted service provider who checks all supplies, chemicals, temperatures and machinery on a regular basis. There is a communication book in</p>

<p>provided.</p>		<p>the laundry and the RN in the psychogeriatric service is notified of any issues. The sluice rooms on both floors are key pad access only and the cleaning trollies are stored in the locked room when not in use.</p> <p>The reconfiguration of two DHB specialist assessment rooms one in the psychogeriatric service and one in the mental health service has not impacted on the laundry and cleaning services. The two rooms are set up in readiness for an admission.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies, procedures and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster, local council 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 17 March 2011. The evacuation plan considers residents with special needs and those with mental and physical disabilities. The two acute assessment rooms added to the service have not impacted on emergency planning. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent being on 26 August 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 available to meet the requirements for the 65 residents. Water storage tanks are available to meet the local council requirements. There is no generator on site. Emergency lighting is available and is tested regularly. There is spare foodstuffs stored for a minimum of three days which was sighted and stored appropriately. Checks and rotation of supplies occurs. Potable water supplies are changed every three months and relabelled. The water storage recommendations by the Whanganui local council is met which is three litres per person per day for up to three days. A check list of supplies on hand is available and checks occur as per the internal audit schedule reviewed.</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. Security systems are in place. Door and windows are locked by staff and checks of the facility are made between shifts.</p> <p>The training programme includes annual training on security, health and safety and emergency management.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and open to the outside gardens. Heating is provided by underfloor heating in the residents' rooms and families confirmed the facilities are maintained at a comfortable temperature. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>

ventilation, and an environment that is maintained at a safe and comfortable temperature.		
<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>Broadview 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 infection control coordinator (ICC). The infection control programme and manual are reviewed annually.</p> <p>An RN is the designated ICC, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CSM and tabled at the monthly infection control meeting and the monthly RN meeting. In addition, the data is presented at the two monthly staff meeting and three-monthly quality meeting. Infection control statistics are entered in the organisation's electronic database and the facility receives feedback against key performance indicators. The organisation's national quality manager is informed of any IPC concerns.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICC has appropriate skills, knowledge and qualifications for the role, having undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the WDHB are available. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC and CSM confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
Standard 3.3: Policies	FA	The IPC policies are reviewed at organisational level and reflect the requirements of the IPC standard and current

<p>and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was 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.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education with residents, when possible, is generally on a one-to-one basis and includes reminders about handwashing, remaining in their room if they are unwell, and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods</p>	FA	<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 infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC and CSM review all reported infections. 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</p>

<p>that have been specified in the infection control programme.</p>		<p>staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The organisation has comprehensive policies and procedures governing the safe use of restraint and enablers which meet the requirement of restraint minimisation and safe practice standards. The restraint coordinator has designated responsibility for restraint and demonstrated a sound understanding of the organisation's policy and practices and her role within this. The restraint coordinator references a restraint folder (sighted) which contains the current job description for this role, and relevant certificates, the restraint register, assessments, monthly data, the restraint/enabler policy, and a copy of the New Zealand standards. The coordinator maintains close oversight of any restraint or enabler use, completes a monthly review of all restraint and enabler use, and holds monthly restraint meetings which is used to raise awareness of staff and discuss further ways to minimise the practice. The quality meeting reviews and discusses restraint every three months. The organisation (HLL) also has a national restraint approval group (RAG) which meets six monthly to review all restraint and enabler use, and also considers how to minimise use. The three-monthly quality meeting also has restraint as a regular agenda item.</p> <p>Since July 2018, restraint register figures sighted reflected a decrease from an average of nineteen restraints a month to nine, however figures are slightly skewed by a change in national reporting in November separating enablers from restraint in totals. On the day of audit, ten restraints were in use in the psychogeriatric unit (three lap belts and seven bedrails) and one bedrail enabler in use in the hospital wing. Restraint is not used as a preferred option but as a last resort to maintain the safety of residents, as evidenced from the restraint folder and from interviews with staff and the coordinator.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education</p>	<p>FA</p>	<p>The restraint/enabler policy details responsibilities and accountabilities in the use of restraint (sighted). A comprehensive assessment and management process is followed for the use of both restraints and enablers which ensures the ongoing safety and wellbeing of residents. This includes cultural considerations as stipulated in the cultural safety policy (sighted). The restraint coordinator provided detailed explanation of the process for determining approval, for recording, monitoring and evaluating any restraints or enablers used. Family or advocates approval is gained should any resident be unable to do so and any impact on family is also considered. This was substantiated by documentation and files viewed.</p> <p>Training updates for all staff are held in the biannual study days.</p>

on restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint/enabler policy details the process for assessment which, initially, can only be undertaken by a registered nurse who then involves the restraint coordinator. Assessment covers the need, alternatives attempted, risk, resident's perception, cultural needs, impact on the family, any relevant life events, any advance directives, expected outcomes and when the restraint will end. Completed assessment templates were sighted in the restraint coordinator's restraint folder evidencing rigorous assessment, including consultation with family.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Restraint and enablers are only used to maintain resident safety and only as a last resort as noted in the policy. This was emphasized by the CNM, Kauri staff and the restraint coordinator. The coordinator outlined how she discusses alternatives with staff. Once approved and in use, any restraint is closely monitored and documented on the restraint record (sighted). The record documents the method approved, when it should be applied, frequency of checks and when it should end. It also details the date, time of application and removal, risk/safety checks, food/fluid intake, pressure area care, toileting, and social interaction during the process.</p> <p>A restraint register is maintained (sighted), updated monthly and reviewed by the coordinator who shares the information with staff at the monthly restraint meeting she organises, as well as at the three monthly quality meeting and six monthly RAG meeting.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>All restraints are reviewed and evaluated consistent with policy and requirements of the standard, as evidenced from the restraint coordinator interview and file review. Evaluation includes review of the process and documentation, including the resident's care plan and risk assessments, future options to eliminate use and the impact and outcomes achieved. Evaluations are included in the monthly restraint meeting agenda and six monthly or sooner if clinically indicated. Review and evaluation is recorded on the back of the restraint assessment form.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate</p>	FA	<p>Staff monitor the restraint in use on a daily basis using the details on the restraint record form. The restraint coordinator maintains oversight and monitoring of all restraints and enablers completing a comprehensive review of each event. This information is collated and presented to the monthly restraint meeting. She also completes a monthly report on restraint and enabler use, investigating and reporting on any adverse outcomes, noting trends in</p>

the monitoring and quality review of their use of restraint.		use, policy compliance and provides this to the quality meeting every three months (minutes sighted). Discussion may indicate changes in practice or staff training required. The RAG meet six monthly and also reviews the information.
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.