

Heritage Lifecare Limited - Roseneath Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Roseneath Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 19 February 2019 End date: 19 February 2019
Proposed changes to current services (if any):	Reconfiguration of five rest home beds to dementia unit beds
Total beds occupied across all premises included in the audit on the first day of the audit:	39

Executive summary of the audit

Introduction

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

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

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Roseneath Lifecare provides rest home and hospital level care for up to 43 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

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

The five beds proposed to be reconfigured to provide dementia level care and the implications of this on Roseneath Lifecare resources were also considered as requested.

This audit has identified areas for improvements relating to documentation within care plans and staffing levels. Improvements have been made to the collection of quality data and the 24-hour activity plan for individual residents which addresses those areas requiring improvement at the previous audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Roseneath Lifecare is provided with Heritage Lifecare Limited business and quality and risk management plans which include the values and vision of the organisation. Monitoring of the services provided to the governing body via the support office was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Incidents and accidents are documented

with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Verbal handovers and communication sheets assist in guiding continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a good standard.

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

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. 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. 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.		Some standards applicable to this service partially attained and of low risk.
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Roseneath Lifecare meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, and safe. On the day of audit replanting and 'rejuvenation' was underway in the central garden which provides outdoor seating.

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Heritage Lifecare Limited has policies and procedures that support the minimisation of restraint and Roseneath Lifecare have implemented these. No enablers were in use at the time of audit. Seven restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, data is 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	14	0	1	2	0	0
Criteria	0	43	0	1	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and is displayed in the entrance way. Those interviewed knew how to do access the complaint process.</p> <p>The complaints register reviewed showed that three complaints have been received this year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. The facility and clinical services managers reported there have been no complaints received from external sources since the previous audit. One complaint had been supported by the local nationwide health and disability advocate and the facility manager stated the advocate currently visits the residents in the facility six to eight weekly.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records and incident files reviewed. Staff understood the principles of open disclosure, which is supported by training and policies and procedures that meet the requirements of the</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to speak English.</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 by Heritage Lifecare Limited, outline the values, and vision of the organisation. The documents described annual objectives and the Roseneath Lifecare's facility manager has developed facility specific operational plans. A sample of weekly and monthly reports by the facility manager and the clinical services manager to the support office and their regional operations manager showed adequate information to monitor performance is reported including financial performance, occupancy, staffing, clinical outcomes, emerging risks and issues.</p> <p>The facility holds contracts with the Wairarapa District Health Board for aged related residential care, aged related hospital services, providing rest home, dementia, respite, health recovery and palliative care.</p> <p>On the day of audit 39 people were residing at Roseneath Lifecare with 11 of these people receiving services within the Dementia Unit known as the Cecilia wing. There were 14 residents receiving rest home level care and two of these people were respite residents. Fourteen people were receiving hospital level care and two of these people were respite residents.</p> <p>The five beds that is rooms 27, 28, 29, 30 and 31, currently designated as dual purpose and rest home beds which are proposed to be reconfigured to provide additional dementia level services were sighted and deemed appropriate for this once the planned physical alterations are made, both within the building and to the fencing and garden areas. (See Safe and Appropriate environment standards 1.4.2 and 1.4.7).</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	<p>FA</p>	<p>The organisation has a comprehensive planned quality and risk system that reflects the principles of continuous quality improvement. At Roseneath Lifecare this includes management of incidents, accidents, compliments and complaints, an internal audit programme, regular resident and family satisfaction surveys, monitoring of outcomes and clinical incidents including but not limited to infections, falls, pressure injuries and medication errors.</p> <p>Roseneath Lifecare meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality, RN and staff meetings. Staff reported their involvement in quality and risk management activities through incident and complaint reporting restraint review, corrective action implementation and meeting attendance. Relevant corrective actions are developed and implemented to address any shortfalls. Examples of these were sighted including sign off within staff meetings. Resident and family satisfaction surveys are completed annually. The most recent survey in March 2018 showed a slight decline in the average overall score out of 5 from 4.1 in 2017 to 4.0 in 2018. The greatest decline between 2017 and 2018 was in</p>

<p>improvement principles.</p>		<p>personal rights and nursing care and these were by 0.4 and 0.3 points respectively. Recreation was the lowest scoring service on 77%. In response to the survey, recreational activities have been increased, and air pumps have been installed. Training sessions on open disclosure and consumer rights have been provided as usual and a weekend 'catch up' session added to ensure all staff are up to date with their mandatory training requirements. The 2019 residents, family and staff surveys are currently underway.</p> <p>Heritage Lifecare Limited policies are based on best practice and were current. The document control system ensures a systematic regular review process, referencing of relevant sources, and approval process. The Roseneath Lifecare managers are responsible for distribution of new and revised documents and removal of obsolete documents and examples of current and completed sign off sheets were sighted on the day of audit.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The managers are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an incident form and some clinical incidents are recorded within the electronic residents' information system the facility is currently transitioning to. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, corrective action plans developed and actions followed-up in a timely manner. The facility manager and clinical services manager are responsible for the investigation and follow up of non-clinical and clinical incidents respectively. Adverse event data is collated and analysed at a local level and reported to the Heritage Lifecare Limited support office for analysis at an organisational level. Clinical incidents are recorded by residents within the electronic system which can be readily viewed by support office staff including the operations manager, the analyst and the quality team.</p> <p>The facility manager described Heritage Lifecare Limited's process which aligns with MOH requirements for essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health recently.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	<p>FA</p>	<p>Heritage Lifecare Limited human resources management policies and processes are based on good employment practice and relevant legislation. Roseneath Lifecare follows the prescribed recruitment process which includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. Copies of current APCs were available onsite for the healthcare professionals providing services to the residents including the general practitioners, podiatrist, physiotherapist, pharmacists, dietician and diversional therapist. A sample of staff records reviewed confirmed the organisation's policies are being consistently</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>implemented and records are maintained onsite at Roseneath Lifecare.</p> <p>Staff orientation includes all necessary components relevant to the role, which includes completion of the Heritage way booklet and competency workbooks relevant to their role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation workbooks and a performance review after a three-month period. The RNs, night caregivers, maintenance staff and diversional therapists hold first aid certificates.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Training accomplishments are displayed in the front entrance. A staff member who is an EN currently working in the Dementia wing is the internal assessor for the programme. The rest homes in the area study collaboratively. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>On the day of audit, no change in staffing numbers for the reconfiguration of the dual purpose and rest home beds into the dementia wing was planned.</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>PA Moderate</p>	<p>Heritage Lifecare Limited provide a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Rostering is completed by the clinical services manager within the Heritage Lifecare Limited electronic system. An afterhours on call roster which is documented on the roster available for staff is in place, with staff reporting that good access to advice is available when needed. At least one staff member on duty has a current first aid certificate and there is a 24/7 RN on call coverage. Observations and review of a rosters confirmed adequate RN cover has been provided, with caregivers not replaced in some instances on the short shift when unplanned absence occurs. Care staff reported there were challenges between midday and 3pm to complete the work allocated to them, especially if there was a caregiver on unplanned leave. A corrective action has been identified in this regard see criterion.</p> <p>On the day of audit, no change in staffing numbers for the reconfiguration of rooms 27 to 31 inclusive from dual purpose and rest home beds into the dementia wing was planned. The reconfiguration of these beds has little or no impact on staffing requirements.</p>
<p>Standard 1.3.12: Medicine Management</p>	<p>FA</p>	<p>The medication management policy at Roseneath Lifecare was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. 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 include the prescriber's electronic 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 is managed in a safe manner if required.</p> <p>Medication errors are reported to the RN and CSM 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 used and meet standing orders guidelines.</p> <p>No additional changes to the medication management system will be required to address the proposed reconfiguration of beds at Roseneath Lifecare.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a</p>	<p>FA</p>	<p>The food service at Roseneath Lifecare is provided on site by one of three cooks and is in line with recognised nutritional guidelines for older people. The menu was implemented by a qualified dietitian in November 2018.</p> <p>A food control plan is in place and registered with the Carterton District Council 20 March 2018. A verification audit of the food control plan is to be undertaken the week of the audit.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken safe food handling qualifications, with kitchen assistants completing relevant food handling training.</p>

<p>component of service delivery.</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>Residents in the secure unit have access to food at any time - day or night.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction with the food service was promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion.</p> <p>In the hospital/rest home area, there are six high acuity residents requiring assistance with meals at mealtime. The layout of the facility, the number of residents requiring food services and the number of residents requiring full assistance evidences minimal supervision available to residents to ensure a pleasurable eating experience (refer 1.2.8.1).</p> <p>No additional requirements around nutritional management will be needed to meet the proposed reconfiguration of bed numbers in the secure unit.</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>Except for the documentation referred to in 1.3.3.4, documentation, observations and interviews verified the care provided to residents of Roseneath Lifecare was consistent with their needs and goals. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the care plan in addition to verbal instruction and oversight from the RNs. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	<p>FA</p>	<p>The activities programme is provided by a diversional therapist and a recreation co-ordinator, who both work five days a week</p> <p>When a resident is admitted to Roseneath Lifecare, time is allocated to spend time with the resident and the family to ascertain residents' needs, interests, abilities and social requirements, and formulate an activity plan. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents.</p> <p>A twenty-four-hour activities plan is in place for residents in the secure unit, to enable a twenty-four-hour approach when addressing their needs. Activities are provided in the secure unit five days a week, by one of the two allocated activities personnel. Activities over the weekends are planned and provided for in all areas of the facility.</p> <p>No changes will be required to the current activities programme offered in the secure unit, for the addition of the five</p>

<p>service.</p>		<p>proposed beds.</p> <p>The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included exercise programmes, an intergenerational playgroup, school visits, church groups, games, visiting entertainers, quiz sessions and daily news updates.</p> <p>Resident and family satisfaction surveys in April-2018 demonstrated dissatisfaction with the number of van outings. That information was used to improve the range of activities offered, by the acquisition of a new more accessible van, and an increase in the number of outings. A recent satisfaction survey has been activated, however results have not yet been collated. The activities programme is discussed at the monthly residents' meetings and minutes indicated residents' input is sought and responded to. Residents and families interviewed confirmed they find the programme meets their needs.</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 at Roseneath Lifecare is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN and passed on at handover</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. Except for the documentation aspect referred to in 1.3.3.4, where progress is different from expected, the service responds by initiating changes to the plan of care provided. Short term care plans were reviewed for infections, pain and 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>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>PA Low</p>	<p>A current building warrant of fitness expiry date 22 June 2019 is publicly displayed in Roseneath Lifecare's reception area.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the facility manager and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting, improvements were being made on the day of audit.</p>

<p>for their purpose.</p>		<p>Staff, residents and family confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>The proposed reconfiguration will involve the addition of external fencing, a secure external door, a secure garden and the movement of the internal secure door. The current placement of services such as the sluice room will not add complexity to the care already provided and not add a burden to the current physical resources.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to Roseneath Lifecare staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 23 October 2012 by Hutt/Wairarapa Fire Service. A full evacuation is required by the approved evacuation scheme and trial evacuations take place six-monthly, the most recent being in October 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for full occupancy. Water storage is located around the complex.</p> <p>Call bells alert staff to residents requiring assistance.</p> <p>Staff report appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff check the premises at night.</p> <p>The proposed reconfiguration will not add a burden to the current emergency and security systems.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control nurse and clinical services manager 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 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. Data is benchmarked internally within the group's other aged care providers.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. Staff reported that the restraint coordinator provides support and oversight for enabler and restraint management in the facility. The clinical services manager and staff interviewed demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, seven residents were using restraints and no residents were using enablers. Staff described the use of an enabler the previous month as being the least restrictive and used voluntarily at the resident's request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives, such as hi-lo beds, and sensor mattresses, have been explored. Staff described their involvement in restraint reviews and trials of alternative options and this was evident on review of the restraint approval group minutes and files reviewed.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA</p> <p>Moderate</p>	<p>Staff and managers described a recent drop in caregiver hours done to align with the organisation’s perceived staffing ratios, which is considered by staff as not taking into account the acuity of the residents or the inclusion of respite residents. The changes have resulted in RNs being unable to have a meal break, one caregiver finishing their shift immediately prior to lunch at midday, and another at 1pm then another at 2pm. Currently there are 11 residents requiring two person hoist assistance and six residents requiring feeding assistance.</p>	<p>The recent changes to the roster do not safely meet the needs of the current residents as indicated by the urgent increase in hours the day following audit.</p>	<p>Review the current roster to provide additional staffing hours to safely meet the needs of current residents.</p> <p>60 days</p>

<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>Six of nine files reviewed did not have documentation in the care plan that described fully the care the resident required to meet all their needs. Four of the six files identified were of residents with varying degrees of behaviours that challenged others. A behaviour assessment had been undertaken and significant challenging behaviours identified. Behaviour monitoring was occurring and indicated evidence of improvement in challenging behaviour episodes; however, no behaviour management strategies that included triggers to these behaviours were documented, nor was there documentation that captured the strategies that had been in place and the effectiveness or ineffectiveness of those strategies.</p> <p>One of the six residents had an acute episode that resulted in an increased level of care and increased needs. The care plan had not been updated since that event to document the change in care needs, despite evidence these changing needs were being attended to by care staff. Pain management strategies and the requirement to monitor for effectiveness of these strategies was not included in two of these six files, where pain was a consideration in behaviours that were being presented. Short term care plans did not consistently include short term problems or identify the presence of one resident's wound and required wound care management.</p> <p>Evidence was sighted to verify all residents received the care required, despite the documentation being absent in the care plan.</p> <p>Interviews with care staff verified care was delivered in line with residents' current needs, however staff acknowledged this was not consistently documented in the care plan.</p>	<p>Care plans do not consistently describe fully the residents' required needs to ensure continuity of care.</p>	<p>Provide evidence that care plans reflect residents' needs and support continuity of care.</p> <p>60 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>External areas are safely maintained and are appropriate to the resident groups and setting, improvements were being made on the day of audit.</p> <p>Staff, residents and family confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>The proposed reconfiguration will involve the addition of external fencing, a secure external door, a secure garden and the movement of the internal secure door. The current placement of services such as the sluice room will not add complexity to the care already provided and not add a burden to the current physical resources.</p>	<p>Security of the external environment to cater for people with dementia is required.</p>	<p>Add fencing , secure external door and secure garden as planned for the reconfigured rooms.</p>

				Prior to occupancy days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.