

Taslin NZ Limited - Otatara Heights Residential Care

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:	Taslin NZ Limited
Premises audited:	Otatara Heights Residential Care
Services audited:	Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services - Psychiatric
Dates of audit:	Start date: 5 April 2019 End date: 5 April 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:	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
	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

Otatara Heights Residential Care and Rehabilitation (Otatara Heights) provides rest home level care for up to 40 residents. The service is privately operated by a husband and wife team; one is the director and the other the manager. They are supported by a clinical nurse manager, business manager and an administration 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, an allied health provider and a general practitioner. Additional standards have been reviewed as requested by the Ministry of Health.

This audit identified five areas requiring improvements relating to care planning documentation, medication management and three areas related to management of restraint. One area related to service delivery plans was previously identified as requiring improvement. Improvements have been made to quality management activities, timeliness of reassessments and evaluation since 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.



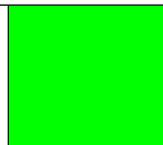
Standards applicable to this service fully attained.

Residents and family members knew about their rights. They found that interactions with staff are respectful. Discrimination was not observed or detected in records and interviews with staff.

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.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. The manager works full time at the facility and has over 15 years' experience in age care.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were being reviewed at the time of audit.

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

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents of Otatara Heights have their needs assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is overseen by 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 medication competent Health care assistants or Registered Nurses, 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.

Mental health: Services are responsive to the needs of the residents. The approach to residents that are placed at the service under a mental health contract is consistent with the recovery model. Medical treatment is provided when needed.

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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There is a current building warrant of fitness.

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.		Some standards applicable to this service partially attained and of low risk.
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The organisation has policies and procedures related to restraint management. Two enablers and one bedside rail restraint were in use at the time of audit. A comprehensive assessment tool is available. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff education related to restraint and behaviour management is offered annually.

Mental health: Staff conveyed that the service does not restrain residents that have mental health issues.

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.

Aged care specific infection surveillance is undertaken, data is analysed and trended. Results are 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	20	0	3	1	1	0
Criteria	0	50	0	3	1	1	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>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided and discussed with residents and families on admission and those interviewed understood how to use the complaints process.</p> <p>The complaints register reviewed showed that six complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Documentation shows any required follow up and improvements have been made where possible. The CNM and manager are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>One complaint was received from the Health and Disability Commission on 08 November 2017. All required documentation related to this complaint was completed. The complaint was signed off as closed by the commissioner on the 30 April 2018 with no further action to be taken. This audit was extended to cover aspects of the complaint as requested by HealthCERT. Documentation sighted identified that the service follow-up included appropriate staff training and education related to residents' rights, restraint and challenging behaviour management and human resources management reviews.</p> <p>Mental health: A resident and a family member confirmed that they knew how to complain and how to access an independent advocacy service to support them in the process.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Aged Care and Residential Disability: 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, ensuring resident information is held securely and privately, exchanging verbal information and enabling phone calls to be taken and made in privacy. Residents who had hearing deficits had call bells on their bedroom doors, that activated a vibrating pager or a light. Similar aids were available to residents with visual impairments.</p> <p>Residents are encouraged to maintain their independence by having access to aids that optimise independence, attending community activities, arranging their own visits to the doctor, participation in clubs and outings of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Sexual needs of residents verified as being met in interview and observations, were not however documented in the care plan (refer criterion 1.3.5.2).</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>Mental health: The residents interviewed and observation indicated that residents can stay in their rooms with the doors closed. They stated that nothing had been taken from their rooms. It was observed that staff knocked on residents' doors to their rooms before entering it. Both residents and the family member spoken with stated that their needs were met. It was observed that some residents were introduced by their title and surnames and others by their first name indicating that the preference of the resident was considered. The care plan of the resident reviewed using tracer methodology included attending activities that catered to their spiritual needs. Attendance was confirmed by the resident. Staff and residents confirmed that visitors can stay in their rooms during visits and some residents stay with friends over night. Residents stated that they have not been abused or neglected and that they had not observed such behaviour at the facility.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination,</p>	<p>FA</p>	<p>Aged Care and Residential Disability: Residents and family members interviewed stated that residents felt safe and were free from, nor had observed any type of discrimination, harassment or exploitation. A general practitioner also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a Code of Conduct as part of their employment agreement. Ongoing education is also provided on</p>

<p>coercion, harassment, sexual, financial, or other exploitation.</p>		<p>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>Mental health: The service provider spoke several times about interacting with and providing services to residents without labelling them in a manner that identifies a deficit such as mental health residents. This is in line with the current trend of not stigmatising people by referring to them by their condition.</p> <p>One example of a resident that refused medication was presented. Support for this person was increased by liaising with the prescriber and exploring why the resident refused the medication. Both residents interviewed stated that they felt safe at the service.</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>Aged Care and Residential Disability: 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 reviewed. There was also evidence of resident/family input into the care planning process. 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 the Hawke's Bay District Health Board (HBDHB) when required. Staff knew how to do so, although reported this was rarely required due to all present residents being able to speak English. Staff can provide interpretation as and if needed in addition to the use of family members for residents if English is not their first language.</p> <p>Residents with visual and hearing deficits have supports in place to aid communication. An interview with a community support person who supports these residents, verified a high regard for the care provided to residents by Otatara Heights.</p> <p>Staff were observed communicating effectively with residents and family members. There was appropriate communication for the needs of all residents. Written information is available and sourced in alternative formats to suit the needs of specific residents when necessary.</p> <p>Mental health: The two residents and the family member interviewed expressed satisfaction about the communication and information they received from the service providers. One resident described a situation where open disclosure occurred.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body</p>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, philosophy, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly reports to the management group which includes one owner,</p>

<p>of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>showed adequate information to monitor performance is reported including financial performance, quality data, staffing, emerging risks and issues. A full governance review, which includes all managers and both owners, is undertaken on a regular basis with the last one being held in January 2019.</p> <p>The service is managed by one owner who holds relevant qualifications and has been in the role for almost six years. She is supported by a business manager who is a chartered accountant and has been in the role since July 2018, the administration manager who has been in the role since January 2014, and a clinical nurse manager (CNM) who has been in the role since June 2017. The CNM is a registered nurse with a current nursing annual practising certificate, a post graduate qualification in aged care and who has worked in aged care for over 21 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The manager and CNM confirm their knowledge of the sector, regulatory and reporting requirements and maintains currency through regular ongoing education related to the roles they undertaken.</p> <p>The service holds contracts with Hawke's Bay District Health Board and the Ministry of Health for rest home level care services covering respite, aged care, young persons under 65 years with chronic health needs, mental health, and accident compensation clients (ACC). At the time of audit there were 39 residents receiving services under various contracts being:</p> <p>Twelve residents receiving care under the Age-Related Residential Care contract;</p> <p>Three residents receiving care under the Long-Term Support – Chronic Health Conditions Residential Care contract;</p> <p>Eight residents receiving care under the Mental Health in Age Related Residential Care contract;</p> <p>One resident receiving care under the Respite and Day Care Services in Aged Related Residential Care contract;</p> <p>Eleven residents receiving care under the Residential – Non-Aged (MOH) contract</p> <p>Four residents receiving care under the ACC Individual Residential Support Services contact. One being respite care.</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</p>	<p>FA</p>	<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, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and wound care.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly management team meetings, the quality and risk team meetings, and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey which was undertaken in March 2019 was still being collated by the manager at the time of audit. She confirmed that any</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>issues that arise are addressed using the corrective action process. During resident interviews it was confirmed that any issues they have are addressed promptly by management. An example reviewed related to a resident who required an alternative form of communication to ensure privacy in their bedroom as they could not hear staff knocking. This corrective action involved engaging the services of a deaf facilitator who stated during interview the service is very responsive to any requests made. The actions taken by the facility are observable and ensure privacy for the resident. Young people with disabilities have input into quality improvements to the service and during interview they confirmed their satisfaction with their input into decision making related to their care, equipment and overall environment.</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 some were under review at the time of audit, for example the restraint policy. (Refer comments in the restraint standards). The document control system ensures a systematic and regular review process, approval, distribution and removal of obsolete documents.</p> <p>The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The risk register was sighted.</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 incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported throughout all levels of the organisation and is discussed at management and staff meetings.</p> <p>The manager and CNM described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, or any other body since the previous audit.</p>
<p>Standard 1.2.7: Human Resource</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</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and annually thereafter. All staff records identified that staff annual appraisals are current.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements and education relevant to physical disability, mental health and young people with physical disabilities. 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. There are two registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments.</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 rationale for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. The four RNs undertake on-call week about and the on-call person is identified on the rosters sighted. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of six weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. The CNM works between 34 to 40 hours per week, Monday to Friday. Two RNs work between 30 to 35 hours per week each, one RN works between 7.5 to 35 hours per week as required. There is at least 70 hours per week RN coverage over morning and afternoon shift. (Four afternoon shifts are covered by an RN).</p> <p>There are dedicated cleaning/laundry, kitchen and activity staff shown on the roster. Cleaning and laundry is undertaken 7am to 4pm Monday to Friday with a dedicated laundry staff member in the weekends. Activities are undertaken 56 hours per week covering Monday to Saturday. The administration manager works eight-hour shifts, Monday to Friday as does the manager. The business manager works off-site five days a week for eight hours per day. Maintenance is undertaken five days a week for 5.5 hours per day. There are dedicated kitchen staff for 17.5 hours a day, Monday to Friday and 13 hours Saturday and Sunday.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or</p>	<p>FA</p>	<p>Mental health: The records of a resident who was recently transitioned to another city in order to be closer to family was reviewed. It showed that a family member was supporting this move and that the resident was keen to be reconciled with family members. Transfer confirmation to another primary care practice was in the file. An updated</p>

<p>Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>lifestyle care plan and the drug chart had been sent to the new rest home the resident was transferred to.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA High</p>	<p>Aged Care and residential disability: 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>An electronic medicine management system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management, other than that around the administering of controlled drugs, which requires improvement. Staff who administer medicines are competent to perform the function they manage. There is, however, no competencies in place for staff who undertake the role of second checker for controlled medications. The clinical nurse manager does not at the present time administer medications, however she will organise for a competency assessment to be undertaken by the clinical nurse specialist (CNS) from the HBDHB, in case administration of medications by her is required in the future.</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 in a locked cupboard with all other medications. During audit, the controlled drugs were placed in a separate locked container, within the cupboard to meet safe medication requirements. Controlled drugs are checked by two staff. 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 to ensure medications are kept within the recommended range, are no longer being kept.</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 was consistently recorded on the electronic medicine chart.</p> <p>Two younger residents who were self-administering medications, one being a spray and one being an inhaler, had no plan in place to ensure this is managed in a safe manner. The residents carried these medications around with them (refer criterion 1.3.5.2).</p> <p>Medication errors are reported to the RN and CNM and recorded on an accident/incident form. The resident and/or</p>

		<p>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>Mental health: One of the residents had prescribed clozapine. Records showed that clozapine levels were monitored. However, discussion with the clinical nurse manager revealed that protocols for monitoring residents on clozapine were not in place.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu was reviewed by a qualified dietitian 18 February 2019. Recommendations made at that time have been implemented.</p> <p>A food control plan is registered with the local council and a verification audit of the food control plan was undertaken 25 May 2018. Areas requiring attention have been attended to.</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 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>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys 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 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of</p>	PA Moderate	<p>Aged Care and Residential Care: Plans reviewed reflected the generalised support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed. Care plans are resident centred and developed with the resident and/or family/whanau.</p> <p>Activities notes, medical and allied health professionals' notations are clearly written, informative and relevant. However, care plans did not consistently evidence service integration with progress notes. This is an area that was previously identified as requiring improvement, and this requirement remains in place. Any change in care required</p>

service delivery.		<p>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>Mental health: Lifestyle care plans included dimensions that supported residents' overall wellbeing. The lifestyle care plans reflected a recovery-based approach. Activities and social interactions had been included in the templates in order to address the previous identified shortfall. Early warning signs and relapse prevention plans had not been included in the lifestyle care plan template and this continues to be an issue that needs to be addressed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Aged Care and Residential Care: Except for that documentation referred to in 1.3.5.2, documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. A resident admitted with a stage four pressure injury has had the injury managed effectively and it is now healed. The environment was observed to be relaxed, with no evidence of disruption by residents who had potentially challenging behaviours, that could distress others.</p> <p>The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is to 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 levels of care provided and in accordance with the residents' needs.</p> <p>Mental health: Interviews with staff, residents and a family member, and verified by record entries showed that service delivery was tailored to the individual needs of residents. This included, for example, plans to improve independence, strategies to reduce anxiety and the provision of medication regimes. Ongoing medical and mental health interventions were provided as instructed. A focus of service delivery was to maintain family and other relationships and to access services in the community. The doors at the facility were open in order for residents to leave for walks at any time or for visitors to come and see their family member or friend. Residents confirmed that they were not locked into their rooms at any time. The residents interviewed and a family member expressed that the residents' mental and physical wellbeing had significantly improved since staying at Otatara Heights.</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</p>	FA	<p>Aged Care and residential disability: The activities programme is provided six days a week, by a recreation officer.</p> <p>A social assessment and history are undertaken verbally on admission to identify residents' interests. A generic activities plan is documented and reviewed every six months, however this plan has no reference to the individual's specific interests, goals, community participation or skills (refer criterion 1.3.5.2). The activities programme is 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>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in</p>

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>interviews with the residents and observed in activity participation. Activities included normal community activities. Individual, group activities and regular events are offered. Examples include an exercise programme, daily walks, numeracy and literature classes, twice weekly outings, visiting entertainers, quiz sessions, coffee groups and daily news updates.</p> <p>Younger residents with disabilities are supported to attend a range of community events that are consistent with their interests and preferences, daily. These include special interest groups, the library, and community programmes that are in line with resident's needs, education programmes and leisure groups.</p> <p>The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered.</p> <p>Mental health: Activities at the facility and in the community were available to the residents. Interviews with residents, the activity coordinator and a family member, confirmed by record entries, showed that residents are supported to attend group and individual activities. Residents stated that they were satisfied with the activities offered.</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>Aged Care and Residential disability: Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Except for those areas referred to in criterion 1.3.5.2, 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 that expected, the service responds by initiating changes to the plan of care. Examples were sighted of short-term care plans being consistently reviewed for infections, 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>Mental health: Lifestyle care plans and or interRAI had been reviewed and evaluated six-monthly. Medical reviews occurred three monthly for all residents. Psychiatric reviews were done at least six-monthly. The implementation of the InterRAI for mental health residents' progress can be tracked systematically. Residents and a family member expressed that their health and wellbeing had improved beyond their expectation.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 01 November 2019) is publicly displayed at the entrance of the facility. Residents and family members confirmed that the physical environment meets their needs.</p>

provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
<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>	FA	<p>Surveillance of infections at Otatara Heights 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 ICN and CNM 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 infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>A norovirus outbreak in October 2017 was dealt with in an appropriate way with guidance from the HBDHB and Public Health.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures which had been in place prior to the current update had references to an outdated restraint standard. The review of the two-yearly restraint policies and procedures which were in process had identified this and the updated policy was in place. The restraint coordinator (CNM) provides support and oversight for enabler and restraint management in the facility.</p> <p>On the day of audit, one resident was using a bedside rail restraint and two residents were using lap belt chair enablers, which were the least restrictive and used voluntarily and are part of the residents' personalised wheelchairs to ensure their safety.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was confirmed during staff interviews.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a</p>	FA	<p>The restraint approval group, made up of the clinical nurse manager (CNM) and one RN, are responsible for the approval of the use of restraints and the restraint processes. It was evident from the interview with the restraint coordinator that there are clear lines of accountability. Restraint is used for safety reasons only and the one restraint in place has been approved by the group. The two residents who have chair lap belts as enablers can manage</p>

<p>process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>these themselves and they are part of the residents' everyday safe care needs when using their personalised chairs.</p> <p>Evidence of family/whānau/EPOA involvement in the initial decision making to use restraint was on file. (Refer comments in 1.3.5.2 related to restraint not being identified on the residents plan of care).</p> <p>Mental health: Staff stated that none of the residents under the mental health contract have been restrained. The records reviewed indicated that restraint did not occur for this resident group. Residents stated that they had not been restrained.</p>
<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>	<p>PA Low</p>	<p>Assessment documents for the use of restraint are included in the restraint policy and procedures. The assessment document sighted identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. No assessment could be found for the resident who had restraint in use. The resident's notes identified that the use of the bedside rail was agreed to by the resident and family members.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Low</p>	<p>The use of restraint is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, such as the use of low beds. Restraint is used for safety reasons only.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. This is documented in the resident's clinical notes. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained to show the number of restraints in use. However, the documentation does not indicate dates for review for the continuation of restraint.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. This last occurred in March 2019.</p>
<p>Standard 2.2.4:</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is evaluated during interRAI reviews. Staff meeting minutes identify that restraint is discussed. Staff confirmed if there are any concerns raised this is identified</p>

<p>Evaluation</p> <p>Services evaluate all episodes of restraint.</p>		<p>in the clinical notes and would be reviewed by the RN.</p> <p>The evaluation of the success of restraint is measured by the safety of the resident and if the restraint has worked for the purpose it was put in place for. This is identified in staff meeting minutes. Whilst this evaluation is not undertaken using the correct restraint evaluation form, evaluation requirements are met as part of the six monthly interRAI assessments and documented in residents' clinical notes.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>PA Low</p>	<p>The restraint committee have input into the residents interRAI assessment when restraint is in use. A quality review of restraint use had not occurred since 2017. Restraint use is reported at staff meetings along with alternatives to restraints, such as low beds, and the effectiveness of the restraint in use. The restraint coordinator confirmed she will ensure the updated policy and procedures are included in staff education. Data reviewed, minutes and interviews with management and staff confirmed that the use of restraint has remained the same over the past year.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA High	<p>Aged Care and Residential disability: An electronic medicine management system was observed on the day of audit.</p> <p>Interview with the care assistant who was administering medications on the day, identified a controlled drug was signed out by two persons in the controlled drug register but that it was not given at the time it was checked out. The medication was given by one staff member at a later time so there was no confirmation it was given to the right resident as is required in safe medication protocol. During staff interviews it was confirmed that the second person checking the controlled medication is not always a person holding</p>	<p>The medicine management system in place does not ensure the safe management of controlled drugs, nor does it ensure medications requiring refrigeration are stored within the correct temperature ranges.</p> <p>Mental health:</p>	<p>Provide evidence the medication management system in place ensures safe storage and administration of medicines.</p> <p>Mental health: Develop a clozapine protocol to ensure the side effects of</p>

		<p>a medication competency. Records and interviews verified this practice was not consistent with policy but that it was not common practice throughout the organisation.</p> <p>The electronic medication record noted the signature of the staff member administering the medication. The second signature however recorded the words “the medication checked out as per the signatures in the controlled drug register”.</p> <p>There were no records of temperatures for the medicine fridge to ensure medications are kept within the recommended range.</p> <p>Mental health: Clozapine was prescribed to one of the residents. Records showed that clozapine levels had been monitored at the required frequency. However, staff were not aware of the indicators that require special monitoring and reporting to the prescriber.</p>	<p>Discussion with the clinical nurse manager revealed that it was not clear who was responsible for monitoring the side effects of this high risk medication. There was no protocol or system in place to identify who is responsible for metabolic monitoring, when to report side effects or other risk related events to the prescriber.</p>	<p>the medication are known and monitored and conditions (for example, infections, flu, high use of coffee or nicotine) that might impact on the clozapine levels are reported to the prescriber.</p> <p>30 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Aged Care and Residential Care: Care plans reviewed were comprehensive in acknowledging the overall individualised needs of the residents regarding activities of daily living. Eight of eight files reviewed had no plan in place that described fully the required nursing strategies to manage the potential risks associated with the resident’s medical problems specifically in relation to pain, epilepsy, respiratory problems and pharmaceutical related risks and required observations.</p>	<p>Care plans do not always describe fully the required support to achieve the desired outcomes identified in the assessment process.</p> <p>Mental health: Records did not include early warning signs and</p>	<p>Provide evidence the care plans describe fully the required support the resident requires to achieve the desired outcomes.</p> <p>Mental health:</p>

		<p>Five of eight files had no advance directive in place to ensure residents wishes were considered when planning residents' care. Eight of eight files had no plan in place to address the resident's sexual needs, despite evidence these were being comprehensively addressed</p> <p>The resident using restraint had no reference to the restraint in the care plan, and subsequent management strategies.</p> <p>Two residents who were self-administering medications had no documentation or plan in place to ensure this was managed in a safe manner.</p> <p>A generalised activity plan was included in all eight care plans reviewed. No documentation was sighted that identifies an assessment of resident's interests, strengths and skills. There was no activity plan in place to address individual residents' specific interests or goals, their community participation, and how these are to be met.</p> <p>Mental health: The lifestyle care plans included goals and support needs in the following areas: communication, hygiene, oral hygiene, dressing, elimination, pressure injury, mobility, transferring, diet, mental health issues, spiritual and activities/social interactions. Those who did not have a lifestyle care plan had an interRAI completed. Early warning signs and relapse prevention plans were not identified in any of the mental health residents' records.</p>	<p>relapse prevention plans.</p>	<p>Record early warning signs and a relapse prevention plan.</p> <p>60 days</p>
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<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>	<p>PA Low</p>	<p>There is an assessment form available to staff which covers all the requirements of this criterion. However, no assessment form could be located for the resident with restraint at the time of audit. An assessment was undertaken on the day of audit and put in the resident's notes. The CNM who is the restraint coordinator confirmed her understanding that an assessment is required for all restraint use.</p>	<p>No restraint assessment form could be found for the resident with restraint in use.</p>	<p>Ensure that restraint assessments are documented prior to commencing restraint.</p> <p>180 days</p>
<p>Criterion 2.2.3.5</p> <p>A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.</p>	<p>PA Low</p>	<p>There is a restraint register in place which identifies that one resident is using bedside rails as restraint and two residents have chair lap belt enablers. There have been no documented injuries related to restraint use since the previous audit. The restraint register documentation does not provide an auditable record of restraint use. This had been maintained until April 2017, but then only partial information was shown. The CNM stated that when the residents' interRAI assessments are undertaken restraint is reviewed as part of this. This is not documented in the register.</p>	<p>The restraint register sighted contained the name of the one resident currently using a restraint; however, there is insufficient information to provide an auditable record of ongoing reviews since 2017.</p>	<p>Provide evidence that restraint review dates are shown in the restraint register so it can be used as an auditable record.</p> <p>180 days</p>

<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	<p>PA Low</p>	<p>The restraint coordinator was in the process of updating policy and procedures at the time of audit. She was not aware that documented reviews were a requirement. There have been no changes in the number of residents using restraint over the past 12 months.</p>	<p>The last documented quality review of restraint was undertaken in April 2017.</p>	<p>Provide evidence that quality reviews for restraint are undertaken to meet the requirements of the Standard.</p> <p>180 days</p>
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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.