

Heritage Lifecare Limited - Resthaven Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Resthaven Lifecare
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 8 July 2019 End date: 9 July 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:	35

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

Resthaven Lifecare provides rest home and dementia level care for up to 49 residents. The service is operated by Heritage Lifecare Limited and managed by a care home manager. Residents and families spoke positively about the care provided.

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

This audit has resulted in no areas identified for improvements.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. A comprehensive Māori health plan and related policies guide care. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The organisation works closely with the local Needs Assessment and Service Coordination Service (NASC), to ensure access to the facility is appropriate and well managed. When a vacancy occurs, relevant information is provided to the potential resident/enduring power of attorney/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission, within the required time frames. The two registered nurses are supported by care and allied health staff and designated general practitioners. Shift handovers and communication sheets guide continuity of care.

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

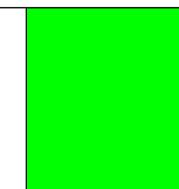
involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by two trained diversional therapists, 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 appropriately trained care staff all of whom have been assessed as competent to do so.

Food service delivery is supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with their meals. The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies is in place.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no restraints were in use at the time of audit.

Infection prevention and control

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

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, with data analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required. There has not been an infection outbreak since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Resthaven Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options to residents and maintaining dignity and privacy. Residents and their Enduring Power of Attorneys (EPOAs) and their family/whānau reported this was occurring. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training as verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Registered nurses and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, vaccination, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the residents file. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff were observed to gain consent for day to day care and adapt to residents requests throughout the</p>

		<p>audit.</p> <p>All files of residents in the secure unit had enacted EPOAs in place. The requirement for these residents to require care in a secure unit had been endorsed by specialist services. Interviews with residents, EPOAs and family/whanau confirmed they are provided with the information they need to make informed choices and give informed consent and were able to provide examples of staff gaining consent on a daily basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents, EPOAs, family/whanau members are given a copy of the Code, which also includes information on the advocacy service.</p> <p>Residents, EPOAs and family/whanau member interviewed were aware of the Advocacy Service, how to access this and their right to have support persons when required.</p> <p>Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed at staff interviews. Updates on the availability of the advocacy service is included in residents' meetings and yearly staff training as sighted in documentation provided.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents at Resthaven Lifecare are assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, eternal community spiritual services, shopping trips, activities, and entertainment. The facility supports the philosophy of Quality of Life, caring, and living life to the highest level of independence.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family/whanau and friends. Family/whanau members interviewed stated they felt welcome when they visited, were able to make tea or coffee drinks in the kitchenette provided for the residents and are comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that four complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The Care Home Manager (CHM) is responsible for complaints management and follow up. All</p>

		<p>staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and their EPOAs, family/whanau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service) by the Care Home Manager (CHM) as part of the admission process, from written information provided, and from discussion with staff. The Code is displayed on posters in the entrance ways of the rest home and dementia service along with brochures on the Code, and advocacy services. In the front entranceway there is information on how to make a complaint and forms to provide feedback.</p> <p>Residents and EPOAs/family members confirmed they, or their relative, receive safe services of an appropriate standard that comply with consumer rights legislation. Monthly residents' meeting minutes evidences discussion on the Code at each residents' meeting. All residents and their families/whanau are offered the opportunity to attend these meetings as confirmed by residents EPOAs, family/whanau.</p> <p>Training records and staff interviewed verified staff have a thorough understanding of the requirements of the Code ensuring services are provided in a manner that respects residents' rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.</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>	FA	<p>Residents, EPOAs and residents' families/whanau 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 staffs' attention to ensuring residents' privacy was observed throughout the audit. Residents' information is held securely. Privacy was ensured while exchanging verbal information, in discussion with families and consultation with the general practitioner (GP). All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by being enabled to continue involvement in past interests, participate in community activities, enjoy regular outings to the local shops, areas of interest and participation in clubs of their choosing. Each care plan sighted included documentation related to the resident's abilities and strategies to maximise independence. Residents in the rest home have a small kitchenette which enables them to access tea, coffee and cold drinks at any time of the day and night as they feel the need. Residents expressed a high level of satisfaction of this being available to them.</p> <p>A review of seven residents' records (four in the rest home and three in the dementia unit) confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been</p>

		<p>identified, documented and incorporated into their care plan.</p> <p>Staff understood the facility 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 records. Abuse and neglect are addressed in the facility house rules and code of conduct.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Maori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau to Maori residents. There is a current Maori Health Plan developed with input from cultural advisers ensuring that residents who identify as Maori will have their health and disability needs met in a manner that respects and acknowledges their individual cultural values and beliefs.</p> <p>The Maori Health plan is guided by the Maori Philosophy of Health embodied in the Maori model of health 'Te Whare Tapa Wha'. These four cornerstones incorporated Whanau (Family health), Tinana (Physical health), Hinengaro (Mental health), Wairua (Spiritual health) as well as Tapu and Noa which are fundamental concepts that under pin all of the above assisting and supporting staff to meet the resident/whanau spiritual and cultural requests.</p> <p>There was one resident in the facility at the time of audit who identified as Maori and one recently deceased whose documentation was reviewed. Documentation in the care plans reflected a person-centred approach that incorporates the individual's need of Maori Health into the services provided. The resident verified a high level of satisfaction with the care being provided at Resthaven Lifecare.</p> <p>Current access to resources includes the contact details of local cultural advisers and guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. There is access to advice from the local District Health Board if additional support is required to support residents who identify as Maori with recent involvement of the Maori nurse specialist input sighted.</p> <p>Interviews verified staff have knowledge to support residents who identify as Maori to integrate their cultural values and beliefs. Cultural safety and Maori Health are included in the yearly staff training programme.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p>	FA	<p>Residents, EPOAs and family/whanau verified that they are consulted on their individual culture, values and beliefs and that staff respect these. Residents' personal preferences, required interventions and special needs are included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. Documentation, observations and interviews verified the individuality afforded to residents in the secure unit, who while attempting to maintain their individuality</p>

<p>services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>are suffering from reduced cognitive function. Staff were observed enabling residents to have choices regarding care routines, meal times and activities required to meet their needs.</p> <p>A resident/EPOA/family/whanau satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met at Resthaven Lifecare.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents, EPOAs and family/whanau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The GP interviewed also expressed satisfaction with the standard of services provided to residents at Resthaven Lifecare.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. Both registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Resthaven Lifecare encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, physiotherapists, occupational therapists, wound care specialist, mental health services for older persons, and education of staff. The GP confirmed the service sought prompt, timely and appropriate medical intervention when required were responsive to medical requests and managed the complex needs of residents as a team. The GP described the facility as proactive towards maintaining and improving the quality of life for residents, for example, recent quality improvements with falls prevention, pressure injury prevention, wound care and the development and implementation of the 'I love music' project to enhance de-escalating challenging behaviours.</p> <p>A commitment to reducing episodes of challenging behaviour in the secure unit is demonstrated by the ongoing commitment of staff to the 'I love music' programme, whereby residents have players loaded with personalised lists of music that connects the resident with the music and memories of their youth. Residents were observed singing and dancing to their own music. Residents were observed to be calm, smiling and relaxed and interacting with staff and visitors. EPOAs and family/whanau confirmed they were consulted and involved in the music to ensure it was meaningful to their family member and the project has been successful in improving the residents' quality of life. They expressed the residents appeared more settled and in general the whole environment calmer.</p>

		<p>'My Memory lane journey' was observed in residents' rooms in the rest home and secure unit and family/whanau verified that it gives family and visitors visual cues that they can have a conversation with the resident about, for example, the family pet, the vehicle they use to drive, their wedding day, family members when they were young. They felt it gave staff and visitors a sense of the essence of who they use to be and what they loved to do before dementia came along. Staff report that it is helpful in understanding the resident's likes and dislikes to enables staff to identify with the resident and provide care and resources that have meaning to them.</p> <p>Other examples of good practice observed during the audit included extra fluid rounds, prompt answering of call bells, regular toileting rounds, and pressure injury prevention strategies. There is a commitment to ongoing improvement in the care provided by staff evidenced by an ongoing initiative aimed at a reduction in the number of falls by the implementation of an exercise and strengthening programme.</p> <p>Staff reported they receive management support for internal and external education through Careerforce training and there is evidence of a compulsory plan for all staff where staff are booked to attend education to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents, EPOAs and family/whanau members verified they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident, EPOA, family/whanau 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 District Health Board or Older Persons Health when required. Staff knew how to do so, although reported this was rarely required due to all residents currently 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>	FA	<p>There is a business plan, reviewed annually, which outlines the purpose, values, scope, direction and goals of the organisation. Each facility, including Resthaven has developed site specific objectives that are linked to the organisation's quality plan objectives. The documents described annual and longer-term operational plans. A sample of monthly reports to support office showed adequate information to monitor performance is reported including occupancy, staffing, health and safety, emerging risks and issues.</p> <p>The service is managed by a Care Home Manager (CHM) who holds relevant qualifications and has</p>

		<p>been in the role for three years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CHM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through the organisation's managers meetings and conferences.</p> <p>The service holds contracts with the Canterbury District Health Board (CDHB) for respite, rest home care, long term chronic conditions (LTCC) and dementia care. Thirty-five residents were receiving services under the contract (14 rest home including one LTCC and 21 dementia care including one respite care resident) at the time of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the CHM is absent, the RN or a temporary CHM from the organisation carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by an RN who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<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 restraint minimisation.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the senior team, quality team and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and feedback at meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed requests for the activity board to be in larger print and personal clothing issues in the laundry. Both have been resolved to the residents' satisfaction.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete</p>

		<p>documents.</p> <p>The CHM 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.</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>	FA	<p>Staff document adverse and near miss events on an incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to support office.</p> <p>The CHM described essential notification reporting requirements, including for pressure injuries. They advised there have been five notifications of significant events, including one for a potential hazard with renovations, made to the Ministry of Health since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</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. An external assessor is used with a staff member being the verifier for the programme. Staff working in the dementia care area have completed 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>Standard 1.2.8: Service Provider Availability</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Observations and review of four weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with General Practitioners and allied health service provider notes. Files were legible with the name and designation of the person making the entry identifiable. Archived records are held securely off site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display on the days of audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter Resthaven Lifecare facility when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families/whanau are encouraged to visit the facility prior to admission and meet with the Care Home Manager (CHM). They are also provided with written information about the service and the admission process. The service operates a waiting list for entry. The organisation seeks updated information from NASC and the general practitioner (GP) for residents accessing respite care.</p> <p>Residents, EPOAs and family/whanau members interviewed verified they are satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements including specialist referrals for dementia services and EPOA consent sighted for those residents to be admitted into the facility.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the District Health Boards 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, EPOA and the family/whanau verified by the GP, staff and residents. At the time of transition between services, appropriate information, including medication records and the care plan is provided</p>

services.		for the ongoing management of the resident. All referrals are documented in the progress notes as verified in files.
<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>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system Medimap was observed on the day of audit. All medication charts had current resident photographs. Staff were observed wearing medication aprons when giving out medication and demonstrated good knowledge of safe medication practices with 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 form 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>There were minimal controlled drugs on site at the time of audit and controlled drugs are stored securely in accordance with requirements. Controlled drugs when in use 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 with evidence of pharmacy checks.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range and consistently recorded.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met including indications for use. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents self-administering medications at the time of audit; however, there are processes in place to ensure this would safely occur if required.</p> <p>Medication errors are reported to the Care Home Manager 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. Standing orders are not used in this facility.</p>
Standard 1.3.13: Nutrition, Safe	FA	The food service is provided on site by a qualified experienced chef and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been

<p>Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>reviewed by a qualified dietitian in April 2019. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and is due to expire December 2020. 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 chef 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 residents, EPOAs and family/whanau 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 and specialised utensils were in use. There are enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p> <p>Residents in the secure unit always have twenty-four-hour access to food and fluids and staff were seen to assist as required, were flexible with the timing of their meals and were observed offering food and fluids throughout the audit.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC service is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC service is made and a new placement found, in consultation with the resident and family/whanau. Examples of this occurring were discussed with the Care Home Manager who confirmed this is conveyed to residents and the family/whanau in a compassionate manner. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences</p>	FA	<p>On admission, residents to Resthaven Lifecare are initially assessed using a range of nursing assessment tools such as initial nursing care assessment, pain scale, falls risk, skin integrity, nutritional screening, social and behaviour assessments and depression scale to identify any deficits and to inform</p>

<p>are gathered and recorded in a timely manner.</p>		<p>initial care planning.</p> <p>All files reviewed had initial assessments completed within 24 hours of admission as per Resthaven Lifecare policy. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verified both RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>Evidence was sighted of comprehensive assessments occurring specifically following residents having a fall and included full neurological monitoring if a head injury is likely or the fall is unwitnessed. In addition, a full post falls assessment is undertaken. Wound assessments are detailed with referral to the wound care nurse as required with photographs taken to verify the wound is healing sighted. A treatment plan is put in place with appropriate documentation, for example, if the resident has increasing difficulty mobilising a mobilisation plan is put in place with a change of position or turning regime implemented which staff sign each shift has been completed with the times frames identified. Referrals to the occupational therapy department and physiotherapy for support to be provided and staff ensuring the resident is on a pressure relieving cushion and mattress were sighted to prevent pressure injuries. High protein nutritional supplements are added to the resident's diet. Verified in documentation sighted and resident, EPOA, family/whanau interviews</p> <p>All residents have current interRAI assessments completed by the two trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the 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 detailed care plans reviewed.</p> <p>The care plan included the required interventions to monitor the resident's medical conditions and potential medication effects, enabling early interventions in detecting a potential problem.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals notations clearly written, informative and relevant. Any change in care required was clearly documented and verbally passed on to relevant staff at shift change overs. Residents, EPOAs and family/whanau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a complex range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources are available, suited to the levels of care provided and in accordance with the residents' needs</p> <p>All residents' files reviewed where episodes of challenging behaviour occurred, had recorded behavioural management plans and 24-hour activity plans. The behaviour management plans included the behaviours the resident exhibited, possible triggers and the strategies to manage the behaviours. The behaviour monitoring chart documented all episodes of challenging behaviour and enabled a review by the GP and RN regarding the effectiveness of the strategies in place.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by an activities co-ordinator whose programme is overseen by two trained diversional therapist from another facility. The CHM is currently supporting the activities co-ordinator to undertake the Careerforce diversional therapy course training.</p> <p>A social assessment and history are undertaken on admission to gain knowledge of the resident. This identifies the resident's needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review. There is a twenty-four hour activities plan for every resident in the secure unit. 'My memory lane journey' is present in residents' rooms completed with photos and narratives of the resident's life from the resident's stories, EPOAs or family/whanau which helps guides visitors and staff in conversations. The resident house cat is a great favourite with residents creating a homely atmosphere.</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 offered are varied. Residents, family/whanau and staff commented on the 'I love music' programme and the benefits residents are gaining from this.</p> <p>The activities programme is discussed at the minuted residents' meetings and residents, EPOA and family whanau input is sought and responded to. Resident, EPOA and family/whanau satisfaction surveys demonstrated satisfaction with the activities programme and that feedback provided is used to improve the range of activities offered. Residents, EPOAs, family whanau interviewed confirmed they were consulted and invited to join in activities and attend residents' meetings</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>reported to the CHM or RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for behaviour management strategies, infections, pain, falls, 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 with photographs taken to evaluate progress.</p> <p>Residents, EPOAs and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents, with the support of EPOAs where necessary, are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents/EPOAs may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, CHM or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the Maori Nurse Practitioner, older person's mental health services. Referrals are followed up on a regular basis by the CHM, RN or the GP. The resident, EPOA and the family/whanau are kept informed of the referral process as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident with an escort to accident and emergency in an ambulance if the circumstances dictate. The yellow envelope system is implemented if transfer or discharge is required</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 01 July 2020) is publicly displayed.</p>

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</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 maintenance personnel 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. The dementia area includes safe external areas for purposeful walking and residents were observed using these.</p> <p>Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned. Residents and family members reported that they were happy with the environment</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes two with full ensuites. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate,</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>

and accessible areas to meet their relaxation, activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is sent offsite, with a dedicated area onsite used to store and sort laundry before transfer. Care staff and laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is now managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff are appropriately trained as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the organisations audit programme.</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>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and 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 16 October 2007. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 17 April 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the total number of residents. Water storage tanks are located around the complex, and there is a generator available for hire if required. Emergency lighting is regularly tested. Requirements meet the Ministry of Civil Defence and Emergency Management recommendations for the region. The emergency plan considers the special needs of people with dementia in an emergency.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p>
Standard 1.4.8: Natural Light,	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden or small patio

<p>Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>areas. Heating is provided by radiators in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Resthaven Lifecare provides a managed environment that minimises the risk of infection to residents, staff and visitors through the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the Care Home Manager. The infection control programme is reviewed yearly, and the policies are reviewed two yearly.</p> <p>The Care Home Manager/registered nurse is the designated infection control co-ordinator whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and tabled at the monthly quality meeting and the staff meeting. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisation's regional clinical and quality support RN, quality assurance lead, and GM clinical and quality are informed of any IPC concerns.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC co-ordinator has appropriate skills, knowledge and qualifications for the role. The IPC co-ordinator has undertaken on-line training on infection control and attended the local DHB infection control study day in February 2019. Well-established local networks with the infection control team at the DHB are available and expert advice from the organisation's clinical risk and quality manager is available if additional support/information is required. The IPC has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC co-ordinator confirmed the availability of resources to support the programme and any outbreak of an infection with the last outbreak reported to have been prior to the last audit.</p>
<p>Standard 3.3: Policies and</p>	<p>FA</p>	<p>IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies</p>

<p>procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>were reviewed in May 2019 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, best practice hand washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility.</p> <p>Staff interviewed verified knowledge of infection control policies and practices and confirmed they receive ongoing training. Staff are offered the opportunity to receive organisation funded influenza vaccinations.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the CHM/IPC co-ordinator. The content of the training was documented and evaluated to ensure it was relevant, current and easily understood by all staff. A record of attendance was maintained. When an increase in infection incidence has occurred or an infection outbreak there is evidence that additional staff education has been provided in response.</p> <p>Education with residents or their EPOA, family/whanau is generally on a one-to-one basis and has included reminders about hand washing, increasing fluid rounds during hot weather and advice about remaining in their room if they are unwell or their family/whanau members not visiting if unwell.</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, ear, nose and throat, gastrointestinal, the upper and lower respiratory tract and MRSA. 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 CHM/IPC coordinator reviews 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. Evidence verified the number of infections is</p>

		low, with the incidence being higher in relation to skin infections.
<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 meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and responsibilities.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers. There have been no restraints ever used at the facility and no enablers in the past three years.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.