

Riverleigh Care Limited - Riverleigh Residential Care

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 Health and Disability Auditing New Zealand 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:	Riverleigh Care Limited
Premises audited:	Riverleigh Care Ltd
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 24 July 2019 End date: 25 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:	59

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Riverleigh Rest Home is privately owned. The service provides; hospital services (hospital and medical); rest home care and residential disability services - Physical. On the day of audit there were 59 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and the general practitioners.

A manager/registered nurse is employed and responsible for the daily operations of the service. A clinical coordinator and stable workforce support her.

The residents and relatives spoke positively about the care provided.

There were no areas identified for improvement. The service is awarded a continued improvement around falls prevention.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Family stated they are kept well informed on their relative's health status. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

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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Riverleigh Rest Home implements a new quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, review of risk and monitoring of health and safety, including hazards. The service meetings include discussion around quality data. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate coverage for the effective delivery of care and there is sufficient staff on duty at all times. An implemented orientation programme provides new staff with relevant information for safe work

practice. The education programme includes mandatory training requirements including supporting younger people with a disability and additional in-service including medical conditions.

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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An admission package is available for prospective residents and their families prior to or on entry to the service. Registered nurses are responsible for each stage of service provision, including assessment, planning and reviewing residents' needs, outcomes and goals. Resident and/or family/whānau input is evident. Care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and allied health professionals.

The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. Medication policies reflect legislative requirements and guidelines. Medication charts sighted had been reviewed at least three-monthly by the general practitioner.

The activities coordinator and activities assistant provide a varied activity programme. The programme includes community visitors, outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for residents.

Residents' food preferences and dietary requirements are identified on admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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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Processes and policies are in place for the management of waste and hazardous substances in place. Incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness.

Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. Documented policies and procedures for cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Policies and procedures are in place for essential, emergency and security services.

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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There are policies and procedures on safe restraint use and enablers. There were six residents voluntarily using enablers and one resident with a restraint. A registered nurse is the restraint coordinator. Resident files included assessments, consents and care plans appropriate to the identified risk and care needed for enablers and restraint. Evaluations and reviews assessing the continued need for restraint were documented. Staff receive training around restraint and challenging behaviours.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator/registered nurse is responsible for coordinating education and training for staff. The infection control coordinator has completed annual external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	1	49	0	0	0	0	0
Criteria	1	100	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>Seven residents (five hospital (including three younger persons, and one respite) and also two at rest home level) and four relatives (two hospital level, including the family of a younger person and two rest home level of care) interviewed, confirmed that information has been provided around the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents stated their rights are respected when receiving services and care. There is a resident rights policy in place. Discussion with four caregivers and four registered nurses (RN) identified they were aware of the Code and could describe the key principles of resident's rights when delivering care.</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>Informed consent processes were discussed with residents and families on admission. Written general consents were signed as part of the admission agreement. Specific consent had been signed by resident/relatives for procedures such as the influenza vaccine. Discussions with registered nurses confirmed that staff understand importance of obtaining informed consent for providing personal care and accessing residents' rooms.</p> <p>Enduring power of attorney (EPOA) evidence is filed in the residents' electronic charts and activated where required.</p>

		<p>Advance directives for health care including resuscitation status had been completed where residents were deemed to be competent. Where residents were deemed incompetent to make a resuscitation decision the GP had made a medically indicated resuscitation decision in consultation with family / whanau. Resident files show evidence that where appropriate the service actively involve family / whanau in decisions that affect their relative's lives.</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>Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the admission process. Pamphlets on advocacy services are available at the entrance.</p> <p>Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Staff receive education and training on the role of advocacy services.</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>The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirmed that family and friends are able to visit at any time and visitors were observed attending the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Community groups visit the home as part of the activities programme.</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 procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal, email and written on the complaints form is maintained by the manager using an online complaints' register. There were 26 complaints for 2018 and five complaints (year to date) for 2019 including one via the advocacy/Health and Disability Commissioner. All complaints/concerns have been managed in line with Right 10 of the Code.</p> <p>A review of complaints documentation evidenced resolution of the complaint, to the satisfaction of the complainant and all complaints have been discussed in weekly head of department and monthly staff and RN meetings.</p> <p>Residents and family members advised that they are aware of the complaint's procedure.</p> <p>The complaint through the advocacy network via the Health and Disability Commissioner has been responded to by the service and is currently with the Health and Disability Commissioner.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service has available information on The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) at the main entrance to the facility. The code of rights is also displayed in the resident areas. A welcome information folder includes information about the code of rights. The resident, family or legal representative has the opportunity to discuss this prior to entry and/or at admission, with the general manager or clinical coordinator. Residents and relatives confirmed they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.</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>The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed were able to describe how they maintain resident privacy. Staff attend privacy and dignity, and abuse and neglect in-service as part of their education plan. Care staff interviewed stated they promote independence with daily activities where appropriate. Resident's cultural, social, religious and spiritual beliefs are identified on admission and they are included in the resident's care plan/activity plan, to ensure the resident receives services that are acceptable to the resident/relatives.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There is a Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The Māori health plan identifies the importance of whānau. There were no residents who identified as Māori at the time of audit. The manager, clinical coordinator and care staff were able to describe how to access information and provide culturally safe care for Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Care plans are reviewed at least six monthly to ensure the clients individual culture, values and beliefs are being met. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular on-site church services, and they are supported to attend other community groups as desired. Recent cultural training included staff from different cultures and nationalities describing their culture and beliefs to the staff group. Staff reported during the audit that this process was enjoyable and meaningful to them.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process meets best practice in regard to recruitment, including reference checks and police vetting. Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Caregivers interviewed could describe how they build a supportive relationship with each resident and stated that their open and family-like approach to care and support assists residents and their families to be able to treat the service like home. Residents interviewed stated they are treated fairly and with respect.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>The manager and team at Riverleigh are committed to providing service of a high standard, based on the provider statement and philosophy. This was observed during the day with the staff demonstrating a caring and respectful attitude to the residents. All residents and families spoke positively about the care provided. The service has implemented new policies and procedures developed by an external consultant that provide a good level of assurance that it is adhering to relevant standards. Care staff and RNs have access to internal and external education opportunities. Staff have a sound understanding of principles of aged care and care of the younger person and stated that they feel supported by management. Regular facility and clinical meetings, and shift handovers enhance communication between the teams and provided consistency of care.</p> <p>The new owner (September 2018) has implemented a series of improvements and new purchases including; new low beds and shower chairs, new flooring, re-decoration throughout, and seven showers upgraded to wet floor showers.</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>The manager and clinical coordinator promote an open-door policy. Relatives/residents are aware of the open-door policy and confirmed on interview that the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through resident meetings (open to family) and annual surveys. Results and areas for improvement are discussed at resident meetings (sighted in minutes) and posted on the resident noticeboard.</p> <p>Accident/incident forms for falls showed relatives had been informed of the incident. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they have</p>

		to pay for that is not covered by the agreement. An interpreter service is available if required.
<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>Riverleigh Rest Home is privately owned. The service provides; hospital (geriatric and medical) medical, rest home care and residential disability services - Physical. All beds are dual-purpose. On the day of audit there were 59 residents; 20 rest home residents, including one respite, and one funded through the Long-Term Support Chronic Health Conditions (LTS-CHC) contract. There were also 39 hospital residents including; six younger persons disabled, three respite, and one LTS-CHC. All other residents were under the ARCC.</p> <p>The facility is managed by an experienced and suitably qualified manager who is a registered nurse (RN) and has been in this position for four years. The manager is supported by a clinical coordinator. The clinical coordinator is responsible for oversight of the clinical service in the facility. The manager and owner are in regular contact. The manager reported that the owner is supportive.</p> <p>There is a documented strategic plan, and quality plan and goals have been reviewed regularly to measure achievements and quality improvements.</p> <p>The general manager maintains an annual practicing certificate and has maintained at least eight hours annually of professional development that is related to managing a rest home and hospital including attending DHB forums and steering groups.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the temporary absence of the general manager the clinical coordinator provides clinical and management oversight of the facility including the on-call requirement. RNs assist with clinical oversight and supervision of staff.</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</p>	FA	<p>The service has implemented a new quality risk management plan, recently purchased from an external consultant. The service has in place a range of policies and procedures to support service delivery that includes hospital level and policies appropriate to younger disabled people. Staff have been introduced to the new policies through training and meetings and are required to sign the reading sheet to acknowledge they have read the policies.</p> <p>There are weekly heads of departments meetings, monthly staff and RN meetings. Meeting</p>

<p>principles.</p>		<p>minutes evidenced discussion around quality data including (but not limited to) complaints, compliments, health and safety, accident/incident, infection control, internal audit and survey results. Trends are identified and analysed for areas of improvement. Meeting minutes document in-depth discussion and ad hoc training linked to audits, incidents, restraint and infection control each month. Individual resident needs are discussed at meetings where issues have been raised. Caregivers confirmed on interview they were kept informed on quality data including corrective actions and quality initiatives.</p> <p>Internal audits are completed as scheduled. Corrective action plans are completed for any corrective actions required. The manager signs off completed corrective actions. Internal audits are discussed along with corrective actions as needed during staff and RN meetings.</p> <p>The service has a health and safety coordinator who has completed health and safety training. The health and safety committee, as part of the staff meeting, review monthly accident/incident reports and review the hazard reports and register. Falls prevention strategies are in place that include the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls. Health and safety information is displayed on the staff noticeboard.</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>As part of risk management and the health and safety framework, there is an accident/incident policy. The service collects incident and accident data monthly and provides reports to all facility meetings. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted.</p> <p>Ten incident forms were reviewed from June 2019 on the online system. All incident forms identified timely RN assessment of the resident and corrective actions or recommendations that had been completed and signed off by the manager. Neurological observations have been completed for unwitnessed falls and any known head injury. The caregivers interviewed could discuss the incident reporting process, they also described the discussion of incidents at monthly meetings.</p> <p>The manager could describe situations that would require reporting to relevant authorities. The service has reported two section 31 notifications (unstageable pressure injury and one absconding).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. The register of RN practising certificates and allied health professionals is current. Eight staff files were reviewed (two RNs, one activities person and five caregivers). All files contained relevant employment</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Care staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>Registered nurses have access to external training that includes clinical education relevant to medical conditions. In-service education delivered by internal and external educators included; end of life/palliative care, caring for younger people with a disability, pressure injury prevention and management, wound care, and pain management. Ad hoc training has been delivered through staff meetings related to new policies and issues raised each month through audits and incidents. Four RNs including the clinical coordinator are interRAI competent. Staff complete competencies relevant to their roles.</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 policy that determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The manager (RN) and clinical coordinator (RN) are on duty during the day Monday to Friday. Both share the on-call requirement for clinical and non-clinical concerns. There are two RNs on the AM and the PM shift (one long shift and one short shift) and one RN at night.</p> <p>There are four caregivers on the AM and four on the PM shift (two long and two short shifts) and two caregivers on the night shift. Caregivers interviewed were happy with staffing levels.</p> <p>Residents and relatives stated there are adequate staff on duty at all times. Staff stated they feel supported by the clinical coordinator and manager who respond quickly to afterhours calls.</p> <p>There are dedicated laundry and cleaning staff.</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>There are paper-based and electronic resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and resident register. Resident clinical and allied health records are integrated. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>Potential residents have a needs assessment completed prior to entry. The service has an admission information pack available for residents/families/whānau available prior to admission or</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>on entry to the service. The information pack includes all relevant aspects of the service. Admission agreements reviewed were signed. Admission agreements in the files reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement. The clinical coordinator described the entry and admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service.</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>	FA	<p>Policies and procedures are in place for safe medicine management that meet legislative requirements and guidelines. Registered nurses and at times a medication competent carer administer medications. They are assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart. Medications are stored safely. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were two residents self-administering medication on the day of audit. The resident had a locked drawer in their room and assessments and three-monthly reviews documented.</p> <p>Sixteen electronic medication charts reviewed met legislative requirements. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication round. The clinical coordinator demonstrated evidence of regular audits undertaken to ensure that registered nurses document the effectiveness of 'as needed' medication.</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>All meals are prepared and cooked on site at Riverleigh Rest Home. The Food Control Plan was developed on 18 February 2019. The chef is responsible for the operations of food services. The kitchen team includes a relief cook and four kitchenhands. All kitchen staff have completed food safety training.</p> <p>There is a four weekly rotating summer and winter menu that has been approved by a dietitian. A food services policies and procedures manual are in place. All food is served directly from the kitchen to residents in the dining room or to their rooms as required. A tray service is available if required by residents.</p>

		<p>All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The cook maintains a folder of resident's dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. The chef caters for dietary preferences including catering for a resident who likes curries.</p> <p>The chef attends resident meetings and at the meetings residents express their feedback on meals and food services. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered.</p> <p>All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Daily hot food temperatures are taken and recorded for each meal. Holding temperatures are taken. Fridge and freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date labelled and stored correctly. The kitchen has a dishwashing area, preparation, cooking, baking and storage areas.</p> <p>The chemicals are stored safely. Safety data sheets are available, and training provided as required. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.</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 entry is declined, the management staff at Riverleigh Rest Home communicate directly with the referring agencies and potential resident or family/whānau as appropriate. The reason for declining entry to the service would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>An initial assessment, clinical risk assessments and care plan are completed on admission to the service. This care plan is used for short-term admissions. Long-term residents have risk assessments completed six-monthly with interRAI assessments undertaken as required, or earlier due to health changes. InterRAI assessments reviewed, were completed within 21 days of admission and six-monthly thereafter. Resident needs and support requirements were identified using the following sources: - discharge summaries, interRAI, risk assessments, medical notes and in consultation with significant others and included in the long-term care plans.</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>Care plans for residents reviewed were resident focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and were sighted in resident files. The residents on respite care had all identified needs included in the respite care plan and the YPD respite and long-term YPD residents had interventions documented in the care plan that were specific to their needs and encouraged participation in activities and community involvement as appropriate.</p> <p>Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. There was evidence of allied health care professionals involved in the care of the resident including occupational therapist, speech and language therapist, physiotherapist, podiatrist and dietitian.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>If a resident's condition alters, a registered nurse initiates a review and if required contacts a general practitioner or nurse specialist. Files sampled demonstrated evidence on the resident's electronic file and paper-based file. Files reviewed demonstrated that families are notified of any changes to their relative's health. This was confirmed in interview.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for residents with wounds. Six wounds and three pressure injuries were documented on the wound log. There was one unstageable pressure injury, a Section 31 had been filed for this and there was input from the wound specialist nurse. The wounds included two cancerous lesions, two lesions and two skin tears. All wounds and pressure injuries had regular photos documenting wound progress.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. Monitoring forms are documented and completed as needed.</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</p>	<p>FA</p>	<p>The service employs an activities coordinator and activities officer who provide activities Monday to Friday. The activities coordinator has been in the role for seven weeks. During weekends caregivers provide some activities and once a month a non-denominational church service is held on a Sunday.</p> <p>The activities programme includes news and views, skittles, indoor walking, board games, cards,</p>

<p>the service.</p>		<p>puzzles, housie and happy hour. Entertainers are invited to the facility twice a month. A pre-school regularly visits. The activity plan includes a visit by the Mr Whippy van, and there are plans to involve canine friends. There are two chickens, budgies and a rabbit at the facility. Regular outings into the community occur, a taxi van is used, and the driver has a current first aid certificate.</p> <p>One-on-one activities occur for residents who choose not to be involved in group activities. Themes and events are celebrated. The needs of younger residents are documented and addressed on a one-to-one basis, with involvement in physical activities including bowls, quoits and skittles. It was noted by staff that there has been an increase in the involvement of younger people in the activities programme since the new activities' coordinator has commenced.</p> <p>An activities assessment is completed on admission. Individual activity plans were seen in long-term resident files. The service receives feedback and suggestions for the programme through monthly resident meetings and direct feedback from residents and families. Residents interviewed spoke positively about the activities programme.</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>Initial care plans for long-term residents were evaluated by a registered nurse within three weeks of admission and long-term care plans developed. There was evidence in the files reviewed that long-term care plans were evaluated by a registered nurse six monthly or earlier for any health changes. Care plans were updated to reflect evaluations and included progress towards meeting goals. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</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>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service. The registered nurses interviewed advised that in the event of a resident being transferred to hospital a yellow envelope is used which includes the contact details of next of kin; a transfer form; medication profile; and progress notes for the previous three days.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	<p>FA</p>	<p>The service has policies and procedures for the disposal of waste and hazardous material. There is an incident system for investigating, recording and reporting all incidents. The chemical supplies are kept in locked cupboards in service areas. The contracted supplier provides the</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>chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment (gloves, aprons, goggles) are readily available to staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 23 September 2019. The maintenance person undertakes preventative and reactive maintenance. The annual maintenance plan includes monthly checks for hot water temperatures, call bells, resident equipment and safety checks. Daily maintenance requests are addressed. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Contractors are available after hours as required.</p> <p>The service is on two levels. There are 33 resident rooms upstairs and 25 rooms downstairs. There was evidence that recent renovations had been undertaken throughout the facility. There are two double rooms downstairs and one upstairs and privacy curtains are in place for all double rooms. There is a lift between floors. The lift has a lift inspection undertaken monthly. The facility has wide corridors with space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade are provided.</p> <p>The registered nurses stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>	<p>FA</p>	<p>Bedrooms have ensuites, and there are also communal toilets and showers. There are adequate numbers of communal bathrooms and toilets throughout the facility. All bedrooms have a hand basin. Appropriately secured and approved handrails are provided, and other equipment is available to promote resident's independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate</p>	<p>FA</p>	<p>Bedrooms provide adequate personal space for residents and staff to move around within the rooms safely. There is a mix of single and double rooms. Double rooms have privacy screens. There is storage space for mobility scooters and wheelchairs. There are two double rooms shared by two married couples.</p>

to the consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are communal lounges and areas for residents throughout the facility, this includes a lounge and dining room downstairs, and a dining room, lounge and library upstairs. This enables residents to participate in activities, dining, relaxing and for privacy. These areas are easily accessed by residents including younger residents with a physical disability. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are policies and procedures for laundry services. There are dedicated laundry and cleaning staff. All laundry is completed on site. The laundry and cleaning staff have completed chemical safety training. The laundry has an entry and exit door. Personal protective wear was readily available. The cleaners' trolleys are stored in a locked area when not in use and all cleaning products were clearly labelled. The effectiveness of cleaning and laundry services is monitored by internal audits and the chemical provider provides ongoing support.</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>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies (torches/batteries) are readily available on each floor with civil defence equipment readily available. The service meets the stored water requirements with at least 20 litres of water per day for 7 days and sufficient food stored on site with barbeques and gas bottles for alternative cooking.</p> <p>Fire and emergency training is provided on staff orientation and ongoing as part of the annual training plan. Six monthly fire drills are completed. There is a first aider on duty at all times.</p> <p>Resident's rooms, communal bathrooms and living areas all have call bells linked to phones carried by staff, each resident also carries a personal call bell. Security policies and procedures are documented and implemented by staff. The buildings are secure at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe</p>	FA	<p>All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated and kept at a comfortable temperature. Residents and relatives interviewed confirmed the environment and the bedrooms are warm and comfortable.</p>

and comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator is the clinical coordinator (a registered nurse) who took on the role a year ago. The infection control coordinator oversees infection control for the facility and staff meeting, heads of department meetings and RN meetings.</p> <p>The service has recently purchased a new IC system with policies from an external consultant. Staff and RN meetings document that new policies have been discussed with staff.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The RN infection control coordinator has completed online IC training and is booked to attend the local DHB IC training next month. The infection control committee is part of the monthly staff meeting as well as the RN meeting. Infection control is a standing agenda item and both meetings document discussion of all infections.</p> <p>The infection control coordinator has access to GPs, local laboratory, the infection control nurse specialist and public health departments at the local DHB for advice and an external infection control consultant specialist.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed by an external consultant and are reviewed regularly.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed for staff.</p>

service providers, support staff, and consumers.		Resident education is expected to occur as part of providing daily cares as appropriate.
<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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the staff and RN meetings. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP who advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit, there were six residents with enablers and one resident with a restraint. All enablers and the restraint were bed rails. Two resident files reviewed; one for restraint and one for enabler use, both documented an assessment, consent and regular reviews. Restraint and challenging behaviour education are included in the training programme.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>A registered nurse is the restraint coordinator with a defined job description. The restraint group meet monthly as part of the staff meeting, the meeting documents review of restraint use along with the RN meeting. Care staff receive education on safe restraint use at orientation and ongoing. There is ongoing education including challenging behaviours. Staff complete restraint competencies. Staff carry out and record restraint monitoring including care delivered during the restraint period.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership, with the resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and</p>

assessment of consumers is undertaken, where indicated, in relation to use of restraint.		observations. Ongoing consultation with the resident and family/whānau are evident. A restraint assessment form was completed for the one resident requiring restraint and one of the six enabler files reviewed. Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation are included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use, risks and cares to be carried out during the restraint episode are included in the care plan. There is an up-to-date restraint register.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluations occur three monthly as part of the ongoing review for residents on the restraint register, and as part of their care plan review. Families and the GP are included as part of this review where possible.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint usage is monitored regularly. The review of restraint use is discussed at the monthly staff and monthly RN meetings. The facility is proactive in minimising restraint. Internal restraint audits are completed. Individual enabler and restraint use are also reviewed during three monthly GP reviews and six-monthly care plan evaluations.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Example; the service introduced a project around falls prevention. The fall preventions project has reduced falls from 29 falls in February to 16 falls for each of May and</p>	<p>The service has implemented a project around reducing falls as part of the 2019 quality plan. The service has implemented a series of interventions with the staff, this has included; (i) Each month the service reviews all falls and identifies all frequent fallers. Each frequent faller has an individual A4 sized poster posted in the staff room. Each poster includes something related to the resident, such as culture or interests, and also falls information and the actions staff need to be aware of. (ii) All falls are discussed in-depth at each of the monthly staff and RN meetings as well as strategies to minimise falls. (iii) Additional falls training has been provided. (iv) The service has purchased a new call bell system. The call bell system includes; each resident having a personal call bell such as a necklace or wrist band. The call bells have a fall alert on them. Bedrooms for frequent fallers have a ‘room scanner’ which alerts the call bell system if the resident gets out of bed. The call bell is linked to staff phones and monitors. This has enabled quicker call bell answering.</p>

		June 2019.	The fall preventions project has reduced falls from 29 falls in February to 16 falls for each of May and June 2019. Service meetings document that falls and falls prevention strategies are reviewed and the plan evaluated monthly.
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End of the report.