

Heritage Lifecare Limited - Clutha Views

Introduction

This report records the results of a Partial Provisional Audit; 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:	Clutha Views Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 29 August 2019 End date: 30 August 2019
Proposed changes to current services (if any):	Partial provisional for 14 rest home beds to become dual purpose.
Total beds occupied across all premises included in the audit on the first day of the audit:	63

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

Clutha Views Lifecare provides rest home, dementia and hospital level care for up to 72 residents. The service is operated by Heritage Lifecare Limited and managed by a care home and village manager and a clinical services manager. The service is requesting to change 14 rest home beds to dual purpose (rest home or hospital beds). Residents and families spoke positively about the care provided.

This certification and partial provisional 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, managers, staff and a general practitioner.

This audit has resulted in continuous improvements in restraint minimisation and infection control. There were no areas requiring improvement relate to either the certification of partial provisional audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and families are provided an information pack on entry to the service. Clutha Views 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 and maintaining dignity and privacy. Staff receive training on the Code as part of the induction process and training is ongoing as verified in the training records.

Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreter service if required. Residents and family members are provided with the information to make informed choices and to give informed consent.

Residents who identify as Māori have their needs effectively met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

Clutha Views Lifecare has linkages with a range of specialist health care providers to support best practice and meet the needs of residents.

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 included the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were 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 included regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and was 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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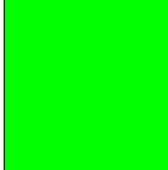
Information is provided to the potential resident/family prior to admission and on admission with a full service pack provided. The multidisciplinary team is available to assess the resident's needs on admission. The registered nurse and the general practitioner complete relevant assessments in a timely manner to meet the requirements of the services contract with the District Health Board. Care plans are individualised based on a comprehensive range of information and accommodate any new problems that might arise. Records reviewed demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis. Residents were referred or transferred to other health services as required.

There were planned activities to cover all services. Residents are provided with a variety of individual and group activities and maintain their links with the community. Twenty-four-hour activities are provided in the dementia unit and activities are personalised to meet the individual needs of residents.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food was safely managed. Residents and families verified satisfaction with the meals provided.

Safe and appropriate environment

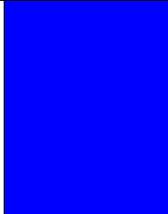
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group 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 was 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.		All standards applicable to this service fully attained with some standards exceeded.
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The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler and six restraints for five residents were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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.		All standards applicable to this service fully attained with some standards exceeded.
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The infection prevention and control programme is led by an experienced and trained infection control coordinator and aims to prevent and manage infections at Clutha Views Lifecare. The programme is reviewed annually. Advice can be sought from specialist infection prevention advisors if needed.

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

Aged care specific infection surveillance is undertaken and results are reported through all levels of the organisation. Follow-up action is taken when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	48	0	0	0	0	0
Criteria	2	99	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>The facility has developed policies, procedures and processes to meet its obligation 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 and maintaining dignity, respect and privacy. Training on the Code is included as part of the induction process for all newly employed staff and in ongoing training as verified in the staff training records. At the time of the audit staff in the dementia unit were observed to offer choices and options to the residents and allowed time for the resident to respond. Family members of residents in the dementia unit interviewed verified that choices were provided to residents and opportunities to attend activities in the rest home/hospital and to go on outings were offered.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>Nursing and care staff interviewed understood the principles of informed consent. Residents' records reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Informed consent policies provided relevant guidance to staff. A separate van outing consent form was sighted and consent for the influenza vaccination was also in the records reviewed. Establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented as relevant</p>

give informed consent.		and these were evidenced in all residents' records reviewed; this included EPOA documents for the residents residing in the dementia unit. Staff were observed interacting and gaining consent for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information is provided during the admission process on the Advocacy Service. A copy of the Code is provided in the admission to service pack. Posters and brochures related to the Nationwide Advocacy Service were displayed and available in the facility. Family members interviewed and residents spoken with were aware of the Advocacy Service and how to access this and their right to have support persons of their choice. Advocacy training is provided to clinical staff annually.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The staff encourage visitors to the facility. Family members interviewed stated they felt very welcomed by the staff and they felt comfortable in their dealings with staff. Residents are assisted to maximise their potential for self-help and to maintain links with their family in the community by attending outings, home visits with family, activities, shopping trips and entertainment provided at other facilities organised by the activities coordinator.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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. The complaints register reviewed showed that ten 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. Two of the most recent complaints are in process. The care home and village manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and their families interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided for residents entering any of the three services provided, being rest home, hospital and memory loss/dementia and discussions were held with the registered nurses during the admission process. The Code is displayed all areas of service delivery along with information on advocacy

		services and how to make a complaint and feedback forms are visible and accessible.
<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>Staff were observed to maintain privacy and respect throughout the audit with residents. All residents are encouraged to maintain their independence by participating in community activities. Residents and families confirmed that they/their relative receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Residents can choose their own GP but most have the contracted medical officer for their medical oversight. Care plans included documentation related to the resident's abilities, and strategies to maximise their independence. The residents in the dementia unit have access to a secure garden from the main dining/lounge area. The residents in the hospital and rest home have access to several lounges and outside areas where they can meet with their family/whānau especially in the warmer months of the year.</p> <p>Residents' records reviewed confirmed that each resident's individual cultural, religious and social requirements, values and beliefs have been identified as part of the admission process. InterRAI information sighted also captures this information. This information is incorporated into their respective care plans.</p> <p>Staff interviewed had a good understanding of what constitutes abuse and neglect. The policy reviewed has clear definitions for staff. Staff understood what to do if they suspected abuse/neglect and how to report this. Education is provided and confirmed in the training records reviewed. Advice is available if required from Aged Concern New Zealand and other agencies and contact details were available.</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 all service areas who identify as Māori to integrate their cultural values and beliefs. The principals of the Treaty of Waitangi are incorporated into the day to day practice, as is the importance of whānau. Policy reviewed guides and gives information about Māori beliefs in relation to illness, the te whare tapa wha model of health and an outline of cultural belief experiences in relation to health in the context of Aotearoa New Zealand. Heritage Lifecare has a Māori health plan and Clutha Views Lifecare has their own template and plan. There were no barriers identified for Māori people to access this service. Currently there is one resident who identifies as Māori and no staff identify as Māori. The one Māori resident has a specific Māori health plan in the records reviewed along with the care plan. Guidelines on tikanga best practice was available.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents and family members interviewed verified that they were consulted on their individual culture, values and beliefs and that staff respected these. The residents' personal preferences and requests, required interventions and special needs, if any, were included in their care plans reviewed. The annual residents' satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation at this facility. The orientation/induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses must complete Code of Conduct training as a requirement for their annual practising certificates. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow should they suspect any form of exploitation if occurring. The individual Heritage Lifecare Limited (HLL) employment contract has a section on expectations and the Code of Conduct that all staff must meet. This was sighted and verified in the personal staff records reviewed.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Clutha Views Lifecare encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example hospice/palliative care team, diabetes nurse specialist, wound care specialist, mental health services for older persons, and education provided to staff. The general practitioner (GP) interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff interviewed reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included how the staff have transitioned from another organisation to Heritage Lifecare Limited (HLL) policies, procedures, residents' records and care plans. The acknowledgement of family visiting was verified and when interviewed family felt welcomed and able to participate with their relative's care. Meals were offered as well if the family member was visiting at lunchtime or had travelled some distance to visit their relative and this was appreciated.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirement of the Code. Residents and family members stated they were kept well informed about any changes to their/their relative's health status and 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.</p> <p>Staff knew how to access interpreter services although reported this was rarely required due to residents at the time of audit able to speak English. Staff can provide interpretation as and when needed and include the use of family as appropriate.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business plan is site specific to Clutha Views Lifecare, is reviewed annually and outlines the purpose, values, scope, direction and goals of the organisation, including goals specific to a person-centred approach to all services. The documents described annual and long-term objectives and associated operational plans. A sample of monthly reports to the support office showed adequate information to monitor performance is reported including financial performance, enquiries, occupancy, human resources, health and safety, compliance, risks and issues and property and 'CAPEX'.</p> <p>Clutha Views Lifecare is managed by a care home and village manager who holds relevant qualifications and has been in the role for sixteen years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at conferences and sector meetings.</p> <p>The service holds contracts with Southern District Health Board (SDHB) for respite, complex medical conditions, hospital and rest home level care, palliative care, long term chronic conditions and rest home dementia care. A ministry of health (MOH) contract for young person with a disability (YPD) is also held. Sixty-three residents were receiving services under the contract (13 dementia care, 26 hospital level and 24 rest home level care) at the time of audit. There were no residents under the respite or YPD contracts.</p> <p>Partial provisional interview:</p> <p>Clutha Views care home and village manager during interview confirmed the planned transfer of rest home beds to hospital only as current occupancy dictates. This is likely to be a staggered transition over a period of time with approval for additional resources (such as beds, staffing, and transfer equipment) from the organisation as required.</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 care home and village manager is absent, the clinical services manager (CSM) or a Heritage Lifecare Ltd (HLL) care home and village temporary manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a senior RN from the facility or HLL 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. All managers and staff incorporate a person-centred approach to all services.</p> <p>Partial provisional interview:</p> <p>The care home and village manager and CSM both have experience to manage the increase in complexities as the hospital level care numbers increase with support from the HLL management team.</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>Clutha Views Lifecare has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, an annual resident satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint practice.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management, quality, health and safety and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, attendance at meetings and individual feedback. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed that staff may have been slow answering bells, this initiated training for all staff in the importance of answering bells and resident meeting minutes confirmed the issue has been addressed.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The care home and village manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an incident form. 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 via the organisations electronic system.</p> <p>The care home and village manager described essential notification reporting requirements, including for pressure injuries. They advised there have been six notifications of significant events 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>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are 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. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed the required dementia training with four staff enrolled in the required education. Of the remaining 32 staff, 20 have completed level 2 or level 3 health and wellbeing training, four are in level 2 training and four in level 3 training. Four staff have declined training. 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>Partial provisional interview:</p> <p>The care home and village manager and HLL operations manager during interview confirmed that staff numbers will increase based on acuity levels, as dual purpose bed residents needs increase from rest home to hospital level care.</p>
<p>Standard 1.2.8: Service Provider</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of four weeks of roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p> <p>Partial provisional interview:</p> <p>The service implements Standards New Zealand 'Indicators for safe aged-care and dementia care for consumers' into its electronic roster system to ensure that staffing reflects the acuity and staffing requirements for all levels of resident care. The service alters staff already according to the needs of the residents in other dual purpose beds.</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>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the resident' records reviewed. Clinical records were current and integrated with GP and allied health service provider records. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Labels are generated and used on the records sighted.</p> <p>The administrator interviewed prepares all records for admission and discharge and the system utilised was explained. The service is still in transition, changing all records over to HLL documentation.</p> <p>Records in use are stored appropriately in the nurses' stations and are out of public view. Additional resident records are stored in a locked room on site and are accessible.</p> <p>Discharged residents' records are stored in envelopes which are clearly labelled and placed in document storage boxes. An electronic records system is in place and records can be retrieved if required. The administrator is fully informed and is aware when archived documents are due to be disposed of as per the records reviewed. A destruction box for obsolete documents is on site and is collected in a timely manner or when full.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable,</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination Service (NASC) for this region. The screening/entry to service process is to determine any potential risks involved in the provision of services. The residents admitted to the dementia unit have been assessed by a specialist.</p>

<p>timely, and respectful manner, when their need for services has been identified.</p>		<p>Prospective residents and/or their family members are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. When residents are admitted for respite care information is sought prior to admission from their GP or the NASC service for an update on their condition and/or needs.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that was provided to them. Records reviewed contained all relevant information about the resident including demographics, assessments, clinical records, diagnostic results and allied health input in accordance with contractual requirements with the Southern District Health Board (SDHB). The admission agreements were signed and safely stored in the Care Home and Village Manager (CHVM) office. Enduring Power of Attorney documentation was verified in the resident's records in the dementia unit. These had been activated as needed.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed effectively in a planned and co-ordinated manner. The GP facilitates the transfer with the assistance of the registered nurses if required. A transfer form is completed and the DHB protocol is followed. Open communication between the services is ensured. Appropriate information is provided for the ongoing management of the resident. A copy of the medication record, care plan and resuscitation status if known is provided and the interRAI information is made accessible. Family of the resident are kept well informed and this is recorded in the resident's progress notes and family communication record.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Medication policies, procedures and guidelines are available to guide staff. A safe system for medicine management (using an electronic system) was observed on the day of the audit. The staff member observed demonstrated a clear understanding of the role and responsibilities related to medicine management. All staff who administer medicines have completed the required medication competency annually. The staff employed in the dementia unit only give out medications in this unit and are overseen by the registered nurse.</p> <p>The service has a contracted pharmacy. The medicines are pre-packaged and checked when delivered to the facility from the pharmacy by a registered nurse. Appropriate checks and balances are completed and weekly and six monthly stock checks are performed and were verified.</p> <p>The GP interviewed reviews all medication records three monthly. Standing orders are not used at this facility. The requirements for pro re nata (PRN) medications are met. All known allergies/sensitivities to medicines are recorded on the electronic medication record and in the medical records for each resident.</p>

		<p>There is currently five residents self-administering medicine at the time of the audit. Appropriate forms and consents are documented to ensure this is managed in a safe manner.</p> <p>There is an implemented process for analysis of any medication errors.</p> <p>Partial provisional interview:</p> <p>There will be no impact directly with the medicine management as registered nurses will still be responsible for the medicine management for hospital level residents, as for the current hospital residents.</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>	<p>FA</p>	<p>The food service is provided on site by the head cook and a team of kitchen assistants and is in line with recognised nutritional guidelines for older people. The four weekly menu plans follows summer and winter pattern and have been reviewed by a qualified dietitian within the last two years (August 2019). Clutha Views Lifecare has a food control plan displayed which expires July 2020.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislative requirements and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The head cook has undertaken a safe food handling qualification and kitchen assistants have completed relevant food handling training and other courses including product education and training. Fridge and freezer temperatures were accurately recorded. A large pantry was available which is not overstocked. All containers are clearly labelled and dated. Cleaning schedules were sighted.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile is developed. The personal food preferences, special diets and modified texture requirements and portion sizes are made known to the kitchen staff and accommodated in the daily meal plan. Residents in the dementia unit have access to food and fluids to meet their nutritional needs at all times. Special equipment to meet resident's nutritional needs is available and accessible if needed.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews and resident meeting minutes reviewed. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance have this provided in a timely manner.</p> <p>Partial provisional interview:</p> <p>There will be no impact on the current service food service provision as the capacity is not changing.</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 resident does not meet the entry criteria the local NASC service is advised to ensure the resident and family are supported to find an appropriate care alternative. This occurs for prospective residents/family and for residents in the facility whose needs change. If the needs of a resident change and they are no longer suitable for the services offered a referral for re-assessment to the NASC is made and a new placement service is arranged in consultation with the resident and family/whānau. 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 are gathered and recorded in a timely manner.</p>	FA	<p>Residents' records reviewed verified that recognised assessment tools are implemented, such as falls risk, skin integrity, nutritional screening and pain scale, as a means to identify any deficits and to inform care planning. The care plans reviewed had an integrated range of resident-related information. All residents have a current interRAI assessment and this was verified electronically, and a copy obtained during this audit. The interRAI assessments are completed by one of three registered nurses interRAI competent including the CSM. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed reflected the care and support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the care plans reviewed. For residents admitted to the dementia unit behaviour management plans are developed based on triggers and interventions of challenging behaviours.</p> <p>The care plans evidence service integration with medical and clinical progress records, activities records, and allied health professionals' input being clearly written, informative and relevant. Any change in care required is documented and verbally handed over to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans and are invited to the multidisciplinary review meetings (MDT).</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</p>	FA	<p>Policies and procedures are available to guide staff on clinical procedures. The attention to meeting a diverse range of resident's individual needs due to the three services provided was evident in all areas of service delivery. The GP interviewed, verified that medical input is sought in a timely manner and medical instructions are followed. Care staff confirmed that care was provided as outlined in the documentation. Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals set and the plan of care. A range</p>

outcomes.		of equipment and resources was readily available suited to the levels of care provided.
<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>	FA	<p>The activities programme is provided by three activities coordinators who are supported with regular contact with a trained diversional therapist holding the National Certificate in Diversional Therapy who is employed at this facility as a healthcare assistant. One of the activities coordinators is currently training to be a diversional therapist and is completing level 4. The activities coordinators are experienced and have worked at this facility from six to 16 years. Activities are provided by the care staff in the weekends and resources are available and prepared in readiness by the activities coordinators. There is an activities communication diary which is used by the activities coordinators and/or staff in the weekends to feed back about any activities provided.</p> <p>The weekly planners are displayed in each area of the home and on the notice board at the entrance to the facility. Photographs of previous recent events are also displayed.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to assist with formulating an activities programme that is meaningful to the residents. The 24 hour clock/plan is used in the dementia unit for all residents highlighting times of the day when activities may be required to meet the needs of the individual residents presenting with challenging behaviours. The plans are reviewed as changes occur and as part of the formal six monthly care plan review.</p> <p>Activities reflects residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered on the programmes sighted. Residents and families are involved as much as possible in improving the programme through residents' meetings and feed-back provided.</p> <p>Residents interviewed verified that they enjoy the programme. One resident likes to be independent but will join in when he wishes to attend.</p> <p>Activities for the dementia unit are specific to the needs and abilities of the residents living there. Activities are offered at time when residents are most active and/or restless. This includes one-on-one and distraction activities. A church service is held every Wednesday.</p> <p>Partial provisional interview:</p> <p>Staff are fully informed that if hospital level resident numbers increase there will be more time allocated for one-on-one activities.</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>Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI re-assessment, or as residents' needs change. Where progress is different than expected the service responds by initiating changes to the plan of care. Challenging behaviour plans are evaluated by the registered nurses in consultation with the care staff who cover this service on a regular basis. Short term care plans are used consistently to manage any issues or problems and evaluated as clinically indicated. The care staff interviewed know to report any changes to the registered nurse on duty at the time or the CSM. Residents and families interviewed provided positive examples of their involvement in evaluation of progress and any resulting changes that may be required.</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 are well supported to access or seek referral to other health and/or disability service providers. The service has a contracted GP but residents may choose to use another medical practitioner. Copies of referral were sighted in the resident records reviewed including to speech language therapist, dietician, hospice services, radiology, neurologist, physiotherapy consultations and/or health clinics at the outpatient services at Clutha First Health Services Ltd – rural hospital or Dunedin Public Hospital (DPH). The resident and family are kept up dated of the referral process. Any urgent referrals are attended to immediately such as sending the resident in an ambulance to the rural hospital services or the SDHB if the circumstances dictate.</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>Partial provisional interview:</p> <p>The service has adequate supplies and waste management resources for an increase in the number of hospital care residents.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 05 June 2020) is publicly displayed.</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. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. There are safe areas leading easily from the dementia wing that allow for purposeful walking and activity in the secure external environment.</p> <p>Residents and family members confirmed they knew the processes they should follow if any repairs or maintenance are required, any requests are appropriately actioned and that they were happy with the environment.</p> <p>Partial provisional interview:</p> <p>Rooms identified for increase to dual purpose are suitable, large and spacious. Three rooms have previously been double rooms and have been refurbished to remove the ceiling track for a curtain to divide the room, therefore these three would only be suitable for couples or as they are now for single occupancy.</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>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes rooms with 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>Partial provisional interview:</p> <p>All rooms requested to change from rest home to dual purpose have either a separate or shared ensuite. These are spacious and can accommodate mobility equipment and aids and care staff for those residents who would require full care.</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</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms currently provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel-chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>

and setting.		<p>Partial provisional interview:</p> <p>The door width is wide enough to move mobility equipment such as a hoist in and out of the rooms. All rooms are spacious for additional equipment and three rooms would adequately fit another bed in and still have sufficient space - although these would only be suitable for couples due to lack of privacy curtains.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. There are several other quiet sitting areas around the facility. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> <p>Partial provisional interview:</p> <p>There is adequate space in communal areas for an increase in the number of hospital residents with mobility aids and equipment.</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>Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is 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. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p> <p>Partial provisional interview:</p> <p>The facility's laundry, equipment and chemicals are suitably large enough to manage the transition from 14 rest home to dual purpose (hospital level) beds.</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 describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 30 April 2015. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 16 April 2019. The orientation programme includes fire and security training. Staff</p>

		<p>confirmed their awareness of the emergency procedures. The emergency plan considers the special needs of people with dementia in an emergency.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs were sighted and meet the requirements for full occupancy of residents and meets the Ministry of Civil Defence and Emergency Management for the region. Water storage tanks are located around the complex, and there is a generator available for hire if required. Emergency lighting is regularly tested.</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> <p>Partial provisional interview:</p> <p>The rooms identified for dual purpose are already included in the emergency and evacuation plans and included in numbers for any civil defence emergency. There are two call bells available in the four double rooms identified for couples only.</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 and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows with views to the gardens outside. Heating is provided by ceiling heaters, heat pumps or underfloor heating in residents' rooms and heat pumps 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>Partial provisional interview:</p> <p>There are large windows to allow natural light and ventilation in the rooms identified for dual purpose.</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</p>	<p>FA</p>	<p>The service has an implemented infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from the GP, pharmacy and SDHB as needed. The infection control programme and manual are reviewed annually. This was last reviewed 10 December 2018.</p> <p>The clinical services manager an experienced registered nurse is the designated infection control coordinator (ICC) whose role and responsibilities are defined in an HLL job description. The CSM is</p>

<p>the size and scope of the service.</p>		<p>currently orientating an RN to this role. Infection control matters, including surveillance results are reported monthly by the clinical services manager to the care home & village manager and tabled at the quality/risk/staff meeting. The committee is developed and implemented and includes the care home & village manager, clinical services manager and representatives from all service areas.</p> <p>Signage is used around the facility. Visitors and staff are informed that if they are unwell they should not enter the facility. The infection control manual kept in the staff room provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood their responsibilities.</p> <p>Partial provisional interview:</p> <p>Infection prevention and control practices will not be affected by the reconfiguration.</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>CI</p>	<p>The training ICC has appropriate skills, intensive care unit experience and has worked in other care settings. The RN interviewed has knowledge and qualifications for the role though recently appointed within the last six months. The ICC has completed the online Ministry of Health (MoH) training online and has attended other relevant training/study days as verified in the training records sighted. The infection control committee consists of the CSM, RN, housekeeping, laundry, head cook, enrolled nurse and caregiver representatives.</p> <p>Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and Public Health as required. The coordinator has access to the residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. The service has recently had two simultaneous outbreaks of infection which was managed efficiently and effectively to ensure the best outcome for the residents and staff involved.</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</p>	<p>FA</p>	<p>Infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies have been reviewed and included appropriate referencing.</p> <p>All staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing techniques and use of personal protective equipment such as gloves and aprons. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

<p>organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</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>Interviews, visual inspection and documentation verified staff have received education in infection prevention and control at induction/orientation and ongoing educational sessions. Education is provided by suitably qualified registered nurses and the ICC. Content of training is documented and evaluated to ensure it is relevant, current and clearly understood. A record of staff participation in the sessions is maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during the summer months.</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 explained by the ICC is appropriate to that recommended for long term care facilities and includes urinary infections, respiratory tract infections, skin, wound, eye, gastro enteritis and other known infections. The ICC reviews all reported infections and these are documented. An infection data care plan/infection short term care plan is commenced and discussed at the staff handover between shifts to ensure early intervention occurs as per the short term care plan.</p> <p>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 regular staff meetings and at staff handovers. Graphs are produced that identify any trends for the current year and comparisons against previous years. Data is benchmarked externally within the organisation. The infection rate is especially low due to the decreased number of residents in the facility currently.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>CI</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The CSM as 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, five residents were using six restraints and one resident was using an enabler, which were the least restrictive and used voluntarily at their request. A similar process is followed</p>

		<p>for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. The CSM has introduced strategies to reduce the number of restraints in use and this demonstrated continuous improvement.</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>The restraint approval group made up of the care home and village manager, CSM and RNs are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored, analysed and has reduced.</p> <p>Evidence of family/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/EPOA. The restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members for example the use of sensor mats, low beds and bedroom close to office area (see criterion 2.1.1.4).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval</p>

		<p>group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>HLL support office restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Following this Clutha Views restraint committee also reviews the data provided by support office restraint committee. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings and back to support office.</p> <p>Minutes of meeting reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the CSM confirmed that the use of restraint has been reduced by 62.5% over the past year, and many residents were using dual restraints where now there is only one resident using dual restraints (refer criterion 2.1.1).</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, 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 3.2.1</p> <p>The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of</p>	CI	<p>The service had an outbreak of norovirus on the 22 July 2019 until the 05 August 2019. This involved both residents and staff. A case log was maintained and updated on a daily basis and correspondence to public health was documented and they were contacted of progress of the outbreak throughout the process. The pandemic planning kits came into practice and were used appropriately by staff. A second outbreak occurred on the 09 August 2019 and the duration of the outbreak lasted to the 24 August 2019. This influenza outbreak was confirmed and reported as required and was significant due to the number of residents and staff involved and the death of one resident. All infection prevention and outbreak control protocol was implemented and the service providers managed to contain this outbreak efficiently and professionally. The daily log reviewed</p>	<p>A continuous improvement rating is made beyond the expected full attainment for the way in which the infection control team coordinated and managed two different infection control outbreaks one after the other. The team worked collaboratively with Public Health South (Health protection officers), staff, families, residents, the GP and organisational management to achieve the best outcome. Residents and families confirmed that they were kept well informed at all times relating to the outbreak. The infection control records during the outbreaks were documented to a high standard. No residents in the dementia service were involved with the second outbreak and only two residents were affected by the first outbreak of gastroenteritis. Post outbreak evaluations highlighted that both rest home and hospital services had residents involved in each separate outbreak but the high incidence of influenza was confined to the hospital wings. Some outcomes recorded included an improvement was required to ensure there was large print infection control signage available and that the</p>

this Standard.		highlighted progress and/or improvements needed. Handovers were provided to staff regularly throughout the outbreak. The daily evaluations and outcomes were reviewed and analysed and any required interventions were put in place. Residents' safety was not compromised in any way. A letter from Public Health South evidenced the success of staff containing both outbreaks in a timely and efficient manner.	isolation protocol was challenging at times although adequate resources were available. Some of the positive outcomes reflected on the consistency of staff and residents demonstrating good handwashing techniques, the use of bleach was very effective for cleaning purposes and the cleaning staff being kept well informed on a daily basis. The team work of all staff was emphasised throughout and this was a significant outcome and ensured the success of managing these two outbreaks effectively and in a timely manner.
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	CI	<p>HLL restraint review committee gathers evidence of restraints on a six-monthly basis and analyses this as benchmarked data for all services (around 40 facilities). In 2018 Clutha Views Lifecare was in line with benchmark recommendations for the number of residents. The CSM noted that factors in not reducing restraints even further were:</p> <ol style="list-style-type: none"> 1. Family concern should the resident fall and injure themselves. 2. Staff and family acceptance that restraints reduced harm. 3. Not identifying ongoing measures to significantly reduce the number of restraints. 4. The link between frequent fallers and skin tear injuries and restraints in use. <p>In reviewing data provided by HLL the CSM identified 'frequent fallers' that now have restraints in place, and the timeframe and area when falls and skin tear injuries occurred.</p> <p>The CSM identified a project to significantly reduce restraints with a consideration for safety for residents and implemented strategies:</p> <ul style="list-style-type: none"> - A 'falls person' was employed from 3pm to focus 	The service has reduced restraint use while maintaining resident safety particularly for frequent fallers by 62.5%

		<p>on falls and skin tear injury prevention.</p> <ul style="list-style-type: none"> - Residents who were restrained as a result of frequent falls were placed in a high staff traffic area next to the office. - Family were consulted throughout and provided with options to reduce the use of restraints while maintaining safety for their family member, for example: hi - lo beds, landing mats, sensor mats and regular monitoring by staff for specific tasks such as toileting, positioning, fluids. - Staff training in restraint reduction and safe strategies were implemented. - CSM reviewed each restraint every month, gaining feedback from staff and family to identify which strategies worked and which ones did not. <p>After six months an evaluation showed that residents restraints were beginning to reduce as well as a reduction in falls for residents who were 'frequent fallers', and skin tears. The CSM continued with the implemented process and used the six-monthly restraint committee as an evaluation of the project.</p> <p>A further evaluation in June demonstrated:</p> <ul style="list-style-type: none"> - A continued reduction in restraint use, as well as falls and skin tears. - Family communication, input and approval has been ongoing. - Safe outcomes for residents and an overall reduction in actual restraints from 16 in 2018 to six at the time of audit. A 62.5% decrease since the implementation of the programme. 	
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End of the report.