

Heritage Lifecare (GHG) Limited - Albarosa, Camellia, Golden Age

Introduction

This report records the results of a Provisional 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 (GHG) Limited

Premises audited: Albarosa||Golden Age||Camellia

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 19 September 2019 End date: 20 September 2019

Proposed changes to current services (if any): Acquisition by Heritage Lifecare Limited.

Total beds occupied across all premises included in the audit on the first day of the audit: 129

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.

General overview of the audit

The Golden Age complex is owned by Golden Healthcare Group (GHG) and is made up of three separate facilities which provide rest home and dementia care for up to 133 residents. The services are part of a group of privately owned and operated facilities managed by a Corporate Services Manager. There are three separate facilities on one site referred to as Golden Age; Camellia Court, Albarosa and Golden Age rest home. Camellia Court and Albarosa are both dementia services. Each of the three facilities within the Golden Age complex is managed by a facility manager with clinical oversight of all three facilities by a senior registered nurse. The organisation's clinical manager, has oversight of all seven facilities in the group. The clinical manager is new to the role. This provisional audit is being completed prior to a proposed sale of six of the group's seven facilities. Residents and families spoke positively about the care provided.

This 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 an interview with the proposed new provider, 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 two areas identified as requiring improvement relating to care plans and infection prevention and control. The corrective actions required at the previous audit in April 2019 are currently being managed by the Canterbury District Health Board.

Consumer rights

Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is provided to residents and their families. All rights described in the Code are respected by managers and staff. Personal privacy, independence, individuality and dignity are supported in all aspects of service delivery.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

There are not currently any residents at the services in this complex who identify as Māori; however, systems and contacts in place would enable those who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers and community health providers to support best practice and meet resident's needs.

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

Organisational management

Golden Healthcare Group business and quality and risk management plans included the scope, direction, goals, statement of the organisation. Monitoring of the services provided to the owner was regular and effective. Experienced and suitably qualified people manage the facilities.

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 includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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 is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

The facilities meet the needs of residents and were clean and well maintained. There was a current building warrant of fitness for the complex. Electrical equipment has been 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 both onsite and offsite 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 and family reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Golden Healthcare Group has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. No restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews is documented should it be required. Staff in each facilities demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

The infection prevention and control programme in place aims to prevent and manage infections. A trained infection prevention and control coordinator leads implementation of the programme. Specialist infection prevention and control advice is available and is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required, including following post outbreak debriefing discussions.

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) |
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| Standards | 0 | 43 | 0 | 2 | 0 | 0 | 0 |
| Criteria | 0 | 91 | 0 | 2 | 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) |
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| 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 |
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| <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 Golden Age Healthcare Group has developed relevant policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and training records verified it is also a component of ongoing training.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies have been fully reviewed and updated and provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Specific consent forms were also in residents' files, in particular for influenza vaccinations.</p> |

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| | | <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented. Relevant documentation is in residents' records, including for those in the dementia services. All files reviewed in the dementia services included applicable enduring power of attorney documentation except for two. These two were with lawyers awaiting changes to be made to the documentation on file as it is no longer applicable. There was evidence of registered nurse and management follow-up on these matters. Staff were observed to gain consent for day to day care and rest home residents spoke of multiple situations in which they are given choices.</p> |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>During the admission process, residents are given a copy of the Code, which also includes information on the advocacy service, plus a brochure on the nationwide advocacy service. Posters and brochures related to the Advocacy Service were displayed and available in each facility. Family members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons with most seeing that they believed they were the main advocate for their family member. There were no examples of the advocacy service having been involved, although this had been specifically offered to one family.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The activity programme is dynamic and includes creative ideas that help to stimulate the residents, especially those in the dementia services. Local churches, schools, entertainment groups, clubs and some volunteers also link with the residents at Albarosa, Camellia Court and Golden Age rest home. An interview with a massage therapist confirmed the welcoming manner of the staff regarding providing additional therapeutic support for the residents.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated</p> |

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| | | they felt welcome when they visited and comfortable in their dealings with staff. All were affirmative about the managers and staff in the various services. |
| <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 Golden Healthcare Group (GHG) complaints policy, flowchart, and associated forms meets the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints registers reviewed showed that 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 show any required follow up and improvements have been made where possible. Each facility manager is responsible for complaints management and follow up in collaboration with the senior registered nurse or clinical manager for clinical issues. Staff described that high risk complaints are escalated to the clinical manager for investigation. All staff interviewed including the senior registered nurse (RN) and clinical manager confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>Residents interviewed informed they were aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service). Sets of admission packs ready for new residents and their family members were sighted for the three services of Albarosa dementia service, Camellia Court dementia service and the Golden Age rest home. These contained brochures on the Code, a copy of the service provider's policy on consumer rights, a brochure on advocacy services and one on how to make a complaint.</p> <p>The clinical managers informed that the registered nurses discuss the Code with new residents in the rest home and with family members from all three services as part of the admission process. Staff informed they also take opportunities to remind people about these issues when</p> |

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| | | <p>appropriate circumstances arise including at residents' meetings. The Code is publicly displayed in both English and te reo Māori in all three facilities. Staff have easy access to the Code in other languages and Tongan, Chinese and Samoan versions have reportedly been accessed when required. Information on how to make a complaint, copies of complaint forms and feedback forms are in the front entrances of each facility.</p> <p>It was confirmed that the prospective provider is familiar with the Code as they are already a service provider for a number of other aged care services.</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>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. A copy of relevant organisational policies and procedures support these practices. Family members stated that despite the number of residents with dementia, staff always respect residents' privacy. Staff were observed to maintain residents' privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by encouraging ongoing family contact and by assisting residents to participate in activities of their choice and to attend community events. Care plans included documentation related to the resident's abilities, and strategies that maximise each resident's independence. Staff described examples of supporting residents' independence that included ensuring equipment such as walking aids is well maintained and encouraging people to attend to any activities of daily living that they are capable of.</p> <p>Staff understood the service provider's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually, as was the need to show regard for people's dignity, privacy and independence.</p> |

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| <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 were not any residents who identified as Māori in any of the three facilities/services at the time of the audit. Staff have access to sufficient information and to appropriate cultural advisors in order to support any prospective resident who identifies as Māori, to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are described in policies and procedures, as is guidance on best practice/tikanga, Māoritanga, an overview of basic te reo Māori and a list of Māori organisations that would facilitate staff access to any additional information and support that may be required. A named cultural advisor is available, and their contact details included in policy documentation. Staff informed that family/whānau involvement is integral to the way in which they work for all residents and this would definitely be integrated into the care and support for any resident who identified as Māori. There is a current Māori health plan developed with input from cultural advisers.</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 verified that they were consulted on their individual culture, values and beliefs and that staff respect these. This was reiterated by family members in the dementia services and confirmed in the results of the resident and family satisfaction surveys.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their activity plan. This information was especially evident in the social profile developed for each resident prior to and on entry to the services. Personal preferences, required interventions and special needs were also included in the action sections in care plans reviewed.</p> <p>An interdenominational service is provided each month, a Roman Catholic priest visits as required and a lay assistant to the priest visits weekly. Residents from several different ethnicities and with specific cultural preferences are being supported and their needs are being accounted for during day to day activities and interactions. Examples of people with dementia having reverted back to their native language were provided and staff described how these situations are being managed.</p> |

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| <p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. There were no examples of such actions evident in the incident reports reviewed. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. All registered nurses have records of completion of the required training on professional boundaries and all staff sign the code of conduct when they commence employment. 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.</p> |
| <p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p> | FA | <p>The service encourages and promotes good practice through accessing advice and assistance from external specialist services and allied health professionals, including for example the hospice/palliative care team when relevant, the diabetes clinic, older persons' health, especially the older persons' mental health services, needs assessors and wound care specialists. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. All policies and procedures were referenced using professional sources of information to guide their content.</p> <p>Registered nurses reported they receive management support for external education and access their own professional networks to support contemporary good practice. A typical example of this was the link with the infection control officer at the local hospital.</p> <p>Other examples of good practice observed during the audit included the diversity and commitment of the diversional therapists and the activities coordinators, who are accessing external information and expertise to complement their work.</p> |
| <p>Standard 1.1.9: Communication</p> | FA | <p>Residents in the rest home and family members of residents in the</p> |

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| <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | | <p>dementia services stated they were kept well informed about any changes to their/their relative's status. They were also being advised about any incidents or accidents and about the outcomes of regular and any urgent medical reviews in a timely manner. This was evident in the communication logs in residents' records reviewed, which included copies of emails when this form of communication had been used. Staff interviewed understood the principles of open disclosure, which is supported by organisational policies and procedures that meet the requirements of the Code.</p> <p>Managers and registered nurses knew how to access interpreter services, although reported this was not usually required as family members generally stepped in when necessary. Communication policy and procedures include a section on interpreter services. A set of communication cards and cues had been developed for one person with dementia who does not speak English.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The Golden Healthcare Group (GHG) strategic plan 2019 – 2024 outlines the purpose, values, scope, direction and goals of the organisation. The document described annual and longer term objectives for the organisation and each of the seven GHG facilities it owns including Golden Age, Camellia Court and Albarosa. The Corporate Services Manager provides a monthly summary report to the owner for each facility on the Golden Age site. A sample of monthly reports to the owner and monthly reports from the facility managers to the corporate services manager showed adequate information to monitor performance is reported including occupancy, financial performance, emerging risks and issues.</p> <p>GHG is managed by an executive team comprising the owner Managing Director, Corporate Services Manager, Operations Manager/Human Resources and Compliance Manager, Administration Manager, Clinical Manager, and Quality Assurance Manager. Each of the three homes on the Golden Age site is managed by a facility manager who holds relevant qualifications and has been in the role for between three and 15 years. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements for each of the managers. Both the corporate services manager and</p> |

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| | <p>facility managers confirmed knowledge of the sector, regulatory and reporting requirements and they maintain currency through ongoing learning and development and relationships with relevant local health sector agencies such as the district health board and needs assessment service coordination service.</p> <p>The facilities hold contracts with the Canterbury District Health Board CDHB, for age related residential care (ARRC), including respite and support of older people with mental health issues and Accident Compensation Cooperation (ACC) for rehabilitation. There were 51 residents in Golden Age rest home, 39 in Camellia Court locked dementia home and 39 in Albarosa locked dementia home on the day of audit. Two people were receiving support under the ACC contract at the time of audit, one resided in Golden Age and the other in Camellia Court. No residents were receiving respite services under the ARRC contract and no residents were under 65 years of age.</p> <p>New Provider Interview September 2019:</p> <p>The new provider (Heritage Lifecare Ltd – HLL) is an established New Zealand aged care provider, currently operating more than 2300 beds (updated Sept 2019) in the sector. This proposed acquisition of GHG facilities will add a further six facilities in the Canterbury region. An organisational structure document for HLL sighted details the reporting lines to the board currently in place. The acquisition of GHG is planned to be different from the other purchases of facilities around the country over recent months as the six GHG facilities will continue to be run as a group with the current Corporate Services Manager in the role of HLL GHG General Manager reporting directly to the HLL CEO. The HLL GHG will retain separate systems such as the quality and risk management system.</p> <p>The HLL GHG transition plan sighted onsite in September is led by an experienced and well-qualified project team. Changes in signage are planned within three months. The transition plan includes all aspects associated with the acquisition. HLL report GHG staff will be invited to the usual regional HLL workshops as relevant to any future planned introduction of documentation and new HLL systems and processes. The HLL project team is working closely with the GHG Corporate Services Manager to ensure a smooth transition of each operation. HLL reported that GHG staff will be invited to the usual regional HLL</p> |
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| | | <p>workshops as relevant to any future planned introduction of documentation, and new HLL systems and processes. The HLL project team is working closely with the GHG Corporate Services Manager to ensure a smooth transition of each operation.</p> <p>It is expected that the senior team will remain in place at each facility. It is expected that existing staff will transfer to the new provider.</p> <p>The prospective purchaser has notified the relevant District Health Board and HealthCert prior to the provisional audits being undertaken.</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>When any of the three facility managers are absent, the GHG relieving facility manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the GHG senior registered nurse or the clinical manager both of whom are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>New Provider Interview September 2019:</p> <p>The prospective provider is not planning any staffing changes. Existing cover arrangements for the day to day operations will remain in place. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.</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> | FA | <p>Golden Healthcare Group (GHG) has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, regular resident and family satisfaction surveys, monitoring of outcomes, and management of clinical incidents including infections, falls and medication.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the GHG organisation's management team, quality and</p> |

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| | | <p>risk team and registered nurses meeting, and Golden Age, Camellia Court and Albarosa quality and risk team and staff meetings. Staff reported their involvement in quality and risk management activities through learning and development, audit activities, meeting attendance and incident reporting. Relevant corrective actions are developed and implemented to address any shortfalls and a corrective action register is maintained. Resident and family satisfaction surveys are completed annually. The most recent survey completed in 2019 showed overall satisfaction with all aspects of the service provided at each of the three facilities. Corrective actions have been taken for all areas with a rating below 100% satisfaction, and feedback on these provided to the resident's meetings along with the survey results.</p> <p>Policies reviewed were current and cover all necessary aspects of the service and contractual requirements. The document control system ensures a systematic and regular review process, approval, distribution and removal of obsolete documents. It is intended that GHG policies and procedures will be retained.</p> <p>The GHG corporate services manager and three facility managers described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Managers are familiar with the Health and Safety at Work Act (2015) and GHG has implemented requirements.</p> <p>New Provider Interview September 2019:</p> <p>The new company to be known as Heritage Lifecare (GHG) Limited will continue to operate the current GHG quality plan and reporting systems within the group. Reporting to the HLL board will be via the HLL CEO by the Heritage Lifecare (GHG) Limited General Manager (currently the GHG Corporate Services Manager). GHG policies and procedures will be retained in the meantime.</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/accident 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 the GHG executive quality and risk team, the</p> |

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| | | <p>GHG registered nurses (RN) meeting, the individual facility quality and risk team, and each staff meeting within each facility.</p> <p>The corporate services manager, facility managers, clinical manager and senior RN described essential notification reporting requirements, including for pressure injuries. They advised there have been notifications of significant events made to the Ministry of Health, since the last audit, for an influenza A outbreak, in Albarosa and Camellia Court locked dementia homes and a norovirus outbreak in the Golden Age rest home.</p> <p>Corrective actions have been undertaken in response to the recent certification audit; however, on the day of this audit the previous CARs remained open.</p> <p>New Provider Interview September 2019:</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The General Manager Clinical and Quality interviewed was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.</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>GHG human resources management policies and processes used by the three homes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of Golden Age, Camellia Court and Albarosa 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. Golden Age, Camellia Court and Albarosa 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 year.</p> <p>Continuing education is planned on an annual and biannual basis, including mandatory training requirements. Care staff have either</p> |

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| | | <p>completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A GHG staff member is the internal assessor for the programme. On the day of audit there were 31 caregivers working in the dementia care areas, 16 in Camellia Court and 17 in Albarosa. Two staff new to the service employed less than one year are enrolled in the required education and the remaining 29 have completed the training. Caregivers described that most staff across the site have completed the NZQA Level 4 Dementia Limited Credit Programme, or the Aged Care Education (ACE) Dementia papers. Staff qualifications are displayed at the entrance to each site. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7) in each of the three homes. Each facility manager 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 a six week concurrent rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p> <p>New Provider Interview September 2019:</p> <p>The prospective owner intends to maintain the current GHG staffing levels and skill mix. The representative for HLL interviewed was able to confirm understanding of the required skill mix to ensure rest home and dementia care residents needs are met. The organisation already provides the range of levels of care (geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies</p> |

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| | | and contractual obligations to be met when delivering these services. |
| <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>At each of the three facilities, all necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Staff interviewed were familiar with the legislation related to health information management, privacy and confidentiality.</p> <p>Archived records are held in a locked downstairs cupboard in the Golden Age rest home and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. Residents' records were in locked nurses' stations in each facility and no personal or private resident information was on public display during the audit.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service, the admission process, costs, the menu and a sample activity schedule. Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Those in the dementia services of Albarosa and Camellia Court had been referred from the older person's specialist mental health services confirming their need for dementia care and copies of these were in files reviewed. Admission processes are carefully planned, where attention to detail around preparing the person's room and reducing anxieties is taken, especially for people moving into the dementia service. An admission pack containing additional information including the Code is provided on entry to the service. Handover processes are arranged for prospective residents being transferred from one of the</p> |

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| | | <p>public hospitals.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them. Files reviewed contained completed demographic detail, assessments, signed admission agreements, initial care plans and GP reviews in accordance with contractual requirements. Most residents' files in the dementia services included consent for their admission from enduring powers of attorney. In the two files where this was not evident, the staff were able to explain the reasons, as noted in standard 1.1.10 above.</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>Any exit, discharge or transfer of a resident is managed in a planned and co-ordinated manner. Escorts are organised as appropriate with family members asked to assist, or one of the staff will step in when necessary. The service uses the DHB's 'yellow envelope' system to facilitate the transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau, which was confirmed by those interviewed. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. Documentation associated with an example of a transfer to acute services was sighted.</p> <p>Any transfer of residents from the Golden Age rest home to the Albarosa or Camellia Court dementia services, or from one of the dementia services to hospital or psychogeriatric care elsewhere is undertaken in a planned way. The managers informed this usually starts with families talking with the GP and the staff and assessment team reiterating the advantages of such a move. Stages of referrals to other health services are documented in the progress notes.</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</p> | FA | <p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>Medicines were stored safely in all three facilities with the use of</p> |

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| <p>guidelines.</p> | | <p>lockable medicine trollies in medicine/treatment rooms with numeric keypads in situ. A safe system for medicine management, using an electronic system, was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Records viewed confirmed all staff who administer medicines in each of the three services are competent to perform the function they manage.</p> <p>Most medicines are supplied to the facility in a pre-packaged format from a contracted pharmacy. A registered nurse and a medication competent caregiver check medicines against the prescriptions when they arrive at the facilities. All medications sighted were within current use by dates. Clinical pharmacist input is available on request, although they will also respond to queries when they deliver medicines, which is most weeks and at least monthly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge are recorded weekly and were within the recommended range.</p> <p>Prescribing practices in the electronic system meet requirements with the dates of commencement and discontinuation of medicines recorded, review dates all within three months evident and all requirements for pro re nata (PRN) medicines clear. Standing orders are not used.</p> <p>There are three residents who were self-administering medications, such as inhalers and creams, at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>There is an implemented process through the incident reporting system for comprehensive analysis of any medication errors.</p> |
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| <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>Food services are provided on site in two kitchens, one in the Golden Age rest home and one in Camellia Court. The Camellia Court kitchen caters for its own residents plus those in the Albarosa dementia service. A qualified chef works in each kitchen assisted by a relief cook and a team of kitchen hands. The chefs meet with the respective managers once a month to discuss requirements or any concerns. Both kitchens use menus that follow summer and winter patterns and as per the internal audit schedule have been reviewed by a qualified dietitian within the last two years to ensure they are in line with recognised nutritional guidelines for older people. Review dates were April/May 2018 (Camellia) and September 2018 (Golden Age) and recommendations made at those times have been implemented. The menus have a five-week rotation cycle.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The services operate with approved food safety plans and registrations issued by the Ministry of Primary Industries with expiry dates of 2 July 2020 (Camellia) and 20 February 2021 (Golden Age rest home). Documentation sighted confirmed that food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Food storage temperatures and systems and kitchen cleaning schedules are also being monitored. Certificates and records were sighted to confirm that the chefs and kitchen hands have undertaken a safe food handling qualification or attended relevant training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Registered nurses are responsible for updating the kitchens with any changes in dietary requirements for residents. Residents in the dementia services have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, was available. The chefs both take time to see the residents' responses to the food and where applicable to talk to them about the food.</p> <p>Evidence of resident satisfaction with meals was verified by rest home</p> |
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| | | resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| <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 | The managers of the Golden Age rest home, and the Albarosa and Camellia Court dementia services could not recall any incidence of a person being declined entry to the services. Local NASC services are reportedly aware of the services provided at these facilities and although one inappropriate referral from the local hospital had occurred, the situation was resolved. A waiting list process is in operation most of the time for the Albarosa and Camellia Court dementia services and family members of prospective residents are advised of this when they enquire. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated. |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | Information is documented using validated nursing assessment tools that include an initial comprehensive nursing assessment on admission, a nutrition assessment, a pain scale, falls risk, continence, skin integrity and cognitive functioning. These assist the registered nurses in identifying any deficits and provide direction for care planning. The sample of care plans reviewed had an integrated range of resident-related information sourced from use of the assessment tools, interRAI outcomes, medical assessments, information from needs assessors and referrers, relatives and where relevant from the residents themselves. All residents have a current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Family members and some residents confirmed their involvement in the assessment process. |

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| <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 reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. As the framework of each care plan is based on the interRAI format, the links between the assessment and care plan processes were transparent. Additional plans had been developed for specific medical concerns, or behaviour management for example, and these complemented the care plans. Behavioural assessments had been completed in the files of residents in Albarosa and Camellia Court and when indicated specific behaviour management plans had been developed and were being reviewed as applicable. All care plans reviewed demonstrated service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant.</p> <p>All care plans sighted were current. Any change in care required had been documented as an update and verbally passed on to relevant staff. Examples of this were sighted and/or quoted. Residents and families reported participation in the development and ongoing evaluation of care plans.</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>Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. Attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision in all three facilities. The GP verified during interview that medical input is sought in a timely manner, that medical orders are followed, and care is of a very high standard. Care staff confirmed that care is individualised and is provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. Residents in the dementia services were being managed in a respectful manner. Staff consistently demonstrated consideration for their safety and competence at using distraction and de-escalation techniques.</p> |

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| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The activities programme in both the Albarosa dementia service and the Golden Age rest home is provided by trained diversional therapists holding the national Certificate in Diversional Therapy, an activities coordinator and volunteers. An additional activities coordinator oversees the programme in the Camellia Court. All activities coordinators and a caregiver are at different levels of working toward their diversional therapy qualification. The activities programmes in the dementia services cover seven days a week. It was observed that the caregivers were actively involved in keeping residents occupied, which according to staff also occurs in the evenings and at weekends.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements, which contributes towards individualised personal profiles and associated activity plans. The managers ask the families of prospective residents to complete the assessment prior to the person being admitted. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. Participation records are completed daily and monthly progress notes written. The resident's overall activity needs are evaluated as part of the formal six-monthly care plan review.</p> <p>Monthly activity programmes are developed. These demonstrated a diverse range of activity related options are being organised. The activities listed and reported reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Where applicable, residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys and informal feedback. The diversional therapists and activity coordinators also use the residents' levels of response to an activity to determine how and if an activity will be repeated. Residents in the rest home confirmed they find the programme interesting and said there is usually something on offer most days.</p> <p>Activities for residents from both of the secure dementia services are specific to the needs and abilities of the people living there. They are offered at times when residents are most physically active and/or restless and each resident's file from these areas that was reviewed included individualised options that could be used over 24-hour</p> |
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| | | timeframes. |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | PA Low | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to a registered nurse.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, and as residents' needs change. Where progress is significantly different from expected, the service responds by initiating changes to the plan of care; however, information about the degree of achievement, or response to the interventions provided is still lacking in routine six monthly care plan reviews. Likewise, resident's progress towards meeting their goals remains unclear. These factors have been raised in a corrective action.</p> <p>Examples of short-term care plans being reviewed, and progress evaluated as clinically indicated, were noted for infections and wound care.</p> <p>Families/whānau interviewed provided examples of involvement in evaluation and review processes. Residents in the rest home were unsure about their involvement but said the nurses were always talking to them about what they want.</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> | FA | <p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or registered nurse sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to outpatient departments and older person's mental health services for example.</p> <p>The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Family/whānau of the residents reported being kept well informed about referrals to other services that were made on behalf of their relative. Such referrals have varied from those for specialist medical input to support services such as the Nurse Maude wound care nurse, the Blind Foundation, the</p> |

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| | | <p>Stroke Foundation and Age Concern.</p> <p>Staff reported that Dementia Canterbury is actively available to talk with families and family members noted the organisation had provided them with relevant information, including via the internet.</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> | FA | <p>Staff in each of the three facilities follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff, which is included in the training programme. Material safety data sheets were available where chemicals are stored, spill kits were readily available, and staff interviewed described what to do should any chemical spill occur.</p> <p>There is provision and availability of protective clothing and equipment throughout the complex and staff were observed using this.</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> | FA | <p>A current building warrant of fitness (expiry date 1 July 2020) was publicly displayed for the complex. The complex is made up of three facilities which are physically linked although managed separately. The homes are Golden Age a 54 bed rest home, Camellia Court a 39 bed locked dementia unit, and Albarosa a 40 bed locked dementia unit. Camellia Court is physically divided into two wings as required by the funder at the time the service was established under what was described as a "Grandfather contract". Albarosa which was built later, was not required by the funder to have this division.</p> <p>Appropriate systems are in place throughout the complex to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Both the two dementia services provided safe indoor and outdoor areas that enabled and encouraged purposeful walking. Access to the outdoors was readily available and residents were observed moving around freely.</p> <p>The testing and tagging of electrical equipment and calibration of bio</p> |

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| | | <p>medical equipment was current for each of the facilities as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free and resident safety was promoted.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned as was clear from review of the maintenance books. Residents and family members were happy with each of the three environments.</p> <p>New Provider Interview September 2019:</p> <p>HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each of the seven facilities. There are presently no plans for any environmental changes in the facilities.</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 complex. This includes ensuites in the Golden Age rest home rooms, and a combination of personal and shared showers and toilets in the Albarosa and Camellia Court locked dementia facilities. Appropriately secured and approved handrails are provided in the toilet and shower areas, and other equipment is available to promote residents' independence.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | <p>FA</p> | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely in all three homes. Two Golden Age rest home bedrooms provide double accommodation and all other rooms throughout the complex are single. Where bedrooms or bathrooms are shared approval has been sought. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters.</p> |

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| | | Staff and residents reported the adequacy of bedrooms. |
| <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 in each of the homes. The dining and lounge areas are spacious with access to safe well-maintained gardens and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> |
| <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 within the Golden Age rest home and off site by a contracted provider. Care staff and dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents and family 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 for each home, who have received appropriate training. These staff undertake the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme, resident and family surveys and observation by managers and other staff. The recent resident and family surveys indicated 100% satisfaction with the cleaning and laundry services.</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>The organisation's policies and guidelines for emergency planning, preparation and response were displayed in flip charts throughout the complex and known to staff. Disaster and civil defence planning guides direct each of the facilities in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on</p> |

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| | | <p>17 April 2019. The orientation programme includes fire and security training. Staff from all three homes confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs were sighted and meet the Ministry of Civil Defence and Emergency Management recommendations for the region. Water storage tanks are located around the complex. The needs of residents in the dementia services in an emergency were included in the plan. 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, including the use of CCTV cameras throughout the complex and signs to alert people to this. Doors and windows are locked at a predetermined time and key pads enable access by authorised staff and visitors. The dementia homes are secure with swipe card access.</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 in the complex are heated and ventilated appropriately. Rooms have natural light, opening external windows and many Golden Age rest home rooms have doors that open onto outside gardens or small deck areas. Heating is provided by a combination of methods in the communal areas and resident rooms which include ceiling heat pumps, panel heating and underfloor heating in the Golden Age rest home residents' rooms. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be</p> | <p>PA Low</p> | <p>The Golden Age rest home and the Camellia Court and Albarosa dementia services implement a Golden Healthcare Group infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a</p> |

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| <p>appropriate to the size and scope of the service.</p> | | <p>comprehensive and current infection control manual, with input from infection control specialists. A corrective action has been raised as it is more than a year since the infection control programme and manual were reviewed.</p> <p>A senior registered nurse/coordinator has been the acting infection prevention and control coordinator since the beginning of 2019. The recently employed clinical manager will take over the role, according to a description of the responsibilities defined in the infection control manual, following completion of the relevant training. Infection control matters, including surveillance results, are reported at quality and risk review meetings which have management, nursing, health and safety, food service and household management representatives present.</p> <p>Signage at the main entrance to the facility reminds visitors about the need to use hand sanitiser for infection prevention and control purposes. The infection prevention and control coordinator informed that relatives are advised about any actual or suspected outbreak and signs are placed on every door advising of the situation. Human resource policies and procedures and the infection control manual provide guidance for staff about remaining away from work when they are unwell. Staff interviewed understood these responsibilities.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | <p>FA</p> | <p>According to training records sighted, the acting infection prevention and control coordinator has attended relevant additional training to obtain the appropriate skills, knowledge and qualifications for the role. Additional support and information are accessed from the infection control team at the local DHB, the community laboratory, the GP and the public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection prevention and control coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p> |

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| <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> | <p>FA</p> | <p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in February 2018 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education, including for hand washing competency checks was last provided by the infection prevention and control coordinator in February and April 2019. In addition, an infection control officer from the local Christchurch Hospital visited all three facilities July and August 2019 to provide more comprehensive infection prevention and control education for staff. Content of the training was documented, and the sessions were evaluated to ensure they were relevant, current and understood. There was evidence that additional staff education had been provided when an infection outbreak occurred.</p> <p>Education with residents is generally on a one-to-one basis and the infection prevention and control coordinator informed these opportunities have included reminders about handwashing and advice about remaining in their room if they are unwell. Staff informed that most education with residents in the dementia services is through guidance and reminders.</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</p> | <p>FA</p> | <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. Documentation sighted confirmed the infection prevention and</p> |

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| <p>infection control programme.</p> | | <p>control coordinator has reviewed all reported infections. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</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, at staff handovers and at quality and risk and health and safety meetings. Graphs are produced that identify trends for the current year, and comparisons against previous year. Data is benchmarked externally with all facilities of the Golden Healthcare Group.</p> <p>Post outbreak debriefs had occurred and a summary report for two recent gastrointestinal infection outbreaks (one of which was suspected only) was developed. This was reviewed and demonstrated a thorough process for investigation and follow up. Three key learnings from the events have since been identified and plans to implement the subsequent recommendations have commenced.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>Golden Healthcare Group (GHG) 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, should they be required. The restraint coordinator provides support and oversight for enabler and restraint management in each of the facilities and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers, which were described by staff as being the least restrictive and used voluntarily at the residents' request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint was described by the restraint coordinator as being potentially used in an emergency as a last resort when all alternatives have been explored. This was evident on review of the quality and risk</p> |

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| | | <p>and registered nurses meeting minutes, and from interviews with staff.</p> <p>The complex has been restraint free for over five years and the GHG policy includes a statement that the organisation is committed to providing a restraint free environment. Staff are required to attain annual restraint and enabler competency.</p> <p>New Provider Interview September 2019:</p> <p>HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for use of enablers. These policies are implemented across the group and a small number of restraint devices are approved for use following assessment. The prospective provider is experienced in the requirements of the standard, as it pertains to aged residential care. HLL GHG will retain their restraint minimisation framework including but not limited to policies, procedures and processes.</p> |
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Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p> | PA Low | <p>Efforts to address a previously raised corrective in relation to the six-monthly evaluations and reviews of residents' care plans had been made. A new form had been developed to facilitate this process. The reviewer is writing a sentence against each relevant aspect on the form; however, in the residents' records reviewed these are basically statements about what the staff are doing, or the person is doing. The statements do not indicate how the listed interventions are, or are not, working towards helping the person meet the goals. A 'yes' or 'no' is then written against each line but the level of progress towards meeting the goals is not documented, there is no evidence that the goals are amended to reflect any gains made, nor which of the factors reviewed contributed to these 'yes'</p> | <p>Evaluation and review processes are in place. However, not all care plan evaluations indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcomes, or required by the standard.</p> | <p>Evaluations of residents' care and support plans shall describe the degree of achievement and/or response to the interventions provided and detail the progress towards meeting their personal goals.</p> <p>180 days</p> |

| | | | | |
|---|--------|---|---|---|
| | | or 'no' decisions. | | |
| <p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p> | PA Low | <p>The infection control programme is clearly defined and documented. This is implemented by the infection prevention and control coordinator and includes the presentation of infection related reports to regular quality and risk and health and safety meetings. The infection prevention and control programme has not been reviewed since before the last review of infection prevention and control policies and procedures in February 2018 over 18 months ago. The standard requires the programme to be reviewed at least annually.</p> | <p>Infection related reports are presented to quality and risk meetings. The infection prevention and control programme is not being reviewed annually.</p> | <p>Ensure the service provider's infection control programme is reviewed at least annually.</p> <p>180 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.