

# Heritage Lifecare (GHG) Limited

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## 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:

<b>Legal entity:</b>	Heritage Lifecare (GHG) Limited
<b>Premises audited:</b>	Brookhaven
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 16 September 2019    End date: 17 September 2019
<b>Proposed changes to current services (if any):</b>	Acquisition by Heritage Lifecare Limited.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	87

# Executive summary of the audit

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## 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

Brookhaven Golden Healthcare Group (GHG) provides rest home and dementia care for up to 92 residents. The service is part of a group of privately owned and operated facilities managed by a corporate services manager. This facility is managed by a facility manager with clinical oversight from a senior registered nurse and a clinical manager, who 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.

The 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 general practitioners.

This audit has resulted in one area identified as requiring improvement related to medication management. The corrective actions required at the previous audit in April 2019 are currently being managed by the Canterbury District Health Board.

## **Consumer rights**

Residents and families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumer Rights (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure residents and family/whānau are provided with appropriate information to assist them to make informed choices on behalf of the residents. The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. There is no evidence of abuse, neglect or discrimination. The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

Five residents and nine family members interviewed spoke very positively about the comfortable, relaxed environments and the care and support provided. Residents' information is kept safe, secure onsite and all entries are legible.

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

## **Organisational management**

Business and quality and risk management plans included the scope, direction, and goals statement of the organisation. Monitoring of the services provided to the owner 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 includes regular individual performance review.

Staffing levels and skill mix meet the changing needs of residents.

## **Continuum of service delivery**

Residents are assessed prior to entry to the service to establish the level of care. The processes for assessment, planning, provision, evaluation, review and exit are provided by suitably qualified staff. InterRAI assessments and individualised care plans are documented.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Twenty-four-hour activity needs are identified in individual care plans.

There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioners (GPs).

The food service is provided onsite and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. A food control plan was in place. Nutritional snacks are available 24 hours.

## **Safe and appropriate environment**

Brookhaven meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. 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. Residents' personal laundry is undertaken onsite and towels and sheets are laundered 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 families reported a timely staff response to call bells. Security is maintained.

## **Restraint minimisation and safe practice**

The organisation 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 this ever be required. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## **Infection prevention and control**

The infection prevention and control management system is in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. The required policies and procedures are documented.

Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## 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)
<b>Standards</b>	0	44	0	0	1	0	0
<b>Criteria</b>	0	92	0	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Brookhaven Retirement Village has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumer 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 and ongoing training as verified in the training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files sampled show that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) or residents and the general practitioner makes a clinically based decision on resuscitation authorisation if required. All files sampled had activated EPOA in the dementia wings. Staff were</p>

		observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.
<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	As part of the admission process residents and family/whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents interviewed were aware of the advocacy service, how to access this and their right to have support persons. The senior registered nurse and staff provided examples of the involvement of advocacy services in relation to residents' care.
<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	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 facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.
<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 and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The 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</p>

		<p>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.</p> <p>There have been no complaints received from external sources since the previous audit. There is an open Health and Disability Commissioner (HDC) complaint which the facility is waiting to receive a decision on, having provided investigation information and resident records as requested by the HDC. Corrective actions have already been implemented in response to the full investigation completed by the new clinical manager.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Māori and English. Family members and residents interviewed were aware of consumers' rights and confirmed that information was provided to them during the admission process.</p> <p>The information pack outlines the services provided. Resident agreements signed either by the resident or by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.</p> <p>New Provider Interview September 2019: The prospective provider is an experienced aged care sector provider. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the requirements of the Code as part of their existing roles. The prospective provider knows and understands the consumer rights that it must adhere to.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a</p>	FA	<p>The residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with the residents in the secure dementia wings able to move freely into the surrounding secure gardens while those in the rest</p>

<p>manner that has regard for their dignity, privacy, and independence.</p>		<p>home wing can go in and out of the facility with no restrictions.</p> <p>Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The senior registered nurses reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. The GPs reiterated that there was no evidence of any abuse or neglect reported. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. The Māori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. It also recognises the importance of whānau. Assessments and care plans document any cultural/spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. There were residents who identify as Māori at the time of the audit and their cultural needs were met as reported by the interviewed family.</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>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whānau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans sampled.</p>

<p><b>Standard 1.1.7: Discrimination</b></p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and this was confirmed by the residents. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. 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. The senior registered nurse stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.</p>
<p><b>Standard 1.1.8: Good Practice</b></p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through ongoing professional development of staff. The general practitioners (GPs) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Policies and procedures are linked to evidence-based practice.</p>
<p><b>Standard 1.1.9: Communication</b></p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards is encouraged.</p>
<p><b>Standard 1.2.1: Governance</b></p>	FA	<p>The Golden Healthcare Group (GHG) strategic plan 2019 – 2024 outlines the purpose, values, scope, direction and goals of the</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>organisation. The document described annual and longer term objectives for the organisation and each of the seven GHG facilities it owns, including Brookhaven Retirement Village (Brookhaven). The Corporate Services Manager provides a monthly summary report to the owner for each site. A sample of monthly reports to the owner and monthly reports from the facility manager 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. Brookhaven is managed by a facility manager who holds relevant qualifications and has been in the role for over four years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Both the corporate services manager and Brookhaven facility manager confirmed knowledge of the sector, regulatory and reporting requirements and they maintain currency through membership of the chamber of commerce and relationships with relevant local health sector agencies such as the district health board and needs assessment service coordination service.</p> <p>The Brookhaven service holds 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 47 residents in the rest home, 27 in one dementia unit and 13 in the other on the day of audit. Two residents were receiving respite services under the ARRC contract, one in the rest home and the other in a dementia wing, one person was receiving support under the CDHB mental health contract and one person was receiving support under the ACC contract at the time of audit. 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</p>
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		<p>(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.</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>	<p>FA</p>	<p>When the Brookfield facility manager is absent, the 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 who 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</p>

		<p>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><b>Standard 1.2.3: Quality And Risk Management Systems</b></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>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 risk team and registered nurses meeting, and Brookhaven 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 Brookhaven. Corrective actions have been taken for all areas with a rating below 100% satisfaction, and feedback on these provided to the residents' meetings along with the survey results. Actions included the replacement of lounge chairs and the complaints process being published in the newsletter as a reminder for families and residents.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements. Policies reviewed were current. The document control system ensures a systematic and regular review process, approval, distribution and removal of obsolete documents.</p> <p>The GHG corporate services manager and Brookhaven facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Both managers are familiar with the Health and Safety at Work Act</p>

		<p>(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>Brookhaven 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 GHG registered nurses (RN) meeting, the Brookhaven quality and risk team, and each group of staff within Brookhaven.</p> <p>The corporate services manager, facility manager, clinical manager and senior RN described essential notification reporting requirements, including for pressure injuries. They advised there have been five notifications of significant events made to the Ministry of Health, since the last audit, for an influenza outbreak, pressure injuries and absconding residents.</p> <p>Corrective actions have been undertaken and submitted to the DHB in response to the recent certification audit; however, on the day of this audit the actions had not been accepted, therefore 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</p>

		and DHB contractual requirements.
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>GHG human resources management policies and processes used by Brookhaven 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 Brookhaven 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. Brookhaven 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 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. All 40 Brookhaven caregivers have dementia training, therefore staff working in the dementia care areas have completed the required education. Twelve staff have completed the NZQA Level 4 Dementia Limited Credit Programme and 28 have completed the Aged Care Education (ACE) Dementia papers. 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><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>GHG human resources management policies and processes used by Brookhaven 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 Brookhaven staff records reviewed confirmed the organisation's policies are being consistently</p>

		<p>implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Brookhaven 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 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. Staff working in the dementia care area have either completed or are enrolled in the required education. All 40 Brookhaven caregivers have dementia training. Twelve staff have completed the NZQA Level 4 Dementia Limited Credit Programme and 28 have completed the Aged Care Education (ACE) Dementia papers. 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>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 and contractual obligations to be met when delivering these services.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>A resident register is maintained of all current and past residents. Resident individual information is kept in paper and electronic format. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with GPs and allied health service provider</p>

		<p>notes. Written records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display 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>The entry to service policy includes all the required aspects on the management of enquiries and entry. Brookhaven Retirement Village's welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whānau where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whānau and residents interviewed confirmed that they received sufficient information regarding the services to be provided.</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>There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</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>	PA Moderate	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>There were no residents self-administering medications. Self-administration medication policies and procedures are in place if required. The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted by the nursing staff.</p>

		<p>Medication audit was conducted, and corrective actions have been acted on.</p> <p>Medication competent care staff in the rest home and dementia wing were observed administering medications safely and correctly. All staff who administer medication have current medication administration competencies.</p> <p>An improvement is required to ensure that (PRN) medicines held in stock are not expired.</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>There is an approved food plan for the service which expires 2 July 2020. Meals are prepared on site and served in the allocated dining rooms. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer menu in place.</p> <p>Residents' food preferences are developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents as and when required, including those in the dementia service. The family members and residents interviewed acknowledged satisfaction with the food service.</p> <p>All food services staff have completed training in food safety/hygiene. The kitchen and pantry were clean, tidy and well stocked. Labels and dates were on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.</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</p>	<p>FA</p>	<p>The senior registered nurses reported that all residents who are declined entry are recorded. When a resident is declined entry,</p>

<p>the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>family/whānau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Residents have their level of care identified through needs assessment by the assessment agency. Initial nursing assessments are completed within the required time frame on admission while residents' care plans and interRAI are completed within three weeks according to policy. Assessments and care plans were detailed and included input from the family/whānau, residents and other health team members as appropriate. Additional assessments are completed according to the need, these included pain, behavioural, falls risk, nutritional requirements, continence, skin and pressure assessments. The nursing staff utilised standardised risk assessment tools on admission. In interviews conducted, family/whānau and residents expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The assessment findings in consultation with the resident and/or family/whānau, inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans are used for short-term needs. The individual behaviour management plans specify prevention-based strategies for minimising episodes of challenging behaviours and describe how the residents' behaviour is best managed over a 24-hour period. Family/whānau and residents interviewed confirmed they are involved in the care planning process. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, district nurses, physiotherapist, podiatrist, dietitian and GP.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	<p>FA</p>	<p>Interventions are adequate to address the identified needs in the care plans. Significant changes are reported in a timely manner and</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>prescribed orders carried out satisfactorily as confirmed by the GPs. The GPs reported that medical input is sought in a timely manner, that medical orders are followed, and care is person centred. Care staff confirmed that care is provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. A residents' activities profile is completed within two weeks of admission in consultation with the family and residents where able. The activities are conducted by three qualified diversional therapists (DTs) covering the rest home and two dementia wings. There are experienced care staff who fill in on weekends or when regular DTs are away.</p> <p>The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. The activities are varied and appropriate for residents in the rest home wing, respite, people living with dementia and are offered from Monday to Sunday. The activities range from word games, walks, ball exercises, housie, bowls, quiz, music, movies, van drives, barbeque, baking and church services. The environment has been enhanced by many wall hangings that prompt discussion and interest. The activity team have initiated a pet friendly environment with meaningful activities including animal care. There is a sensory modulation room in the dementia unit that assist in reducing challenging behaviours.</p> <p>A twenty-four-hour diversional therapy plan has been developed for each individual resident based on assessed needs and these were sighted in all files sampled. Residents' files have a documented activity plan that reflected their preferred activities of choice and these are evaluated every six months or as necessary. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction survey. Outcomes from the survey were communicated with residents the</p>

		<p>residents' meeting on 12 June 2019.</p> <p>The residents were observed to be participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents and family members interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented on each shift by care staff in the progress notes. The registered nurses complete progress notes daily and as necessary. All noted changes by the care staff are reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change. These are carried out by the RNs in conjunction with family, GPs and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whānau are included and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents and family/whānau are supported to access or seek referral to other health and/or disability service providers where required. If the need for other non-urgent services are indicated or requested, the GPs and the nursing team sends a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses or the GPs. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to the public hospital in an</p>

		ambulance if required.
<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>Brookhaven staff 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. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Brookhaven has a current building warrant of fitness (expiry date 1 July 2020) which was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained, in the rest home and both dementia services. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free and resident safety was promoted. 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>External areas are attractive, 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. Review of the maintenance book provided evidence of this. Brookhaven residents and family members were happy with the environment as indicated in the annual survey results reviewed.</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 GHG 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>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout Brookhaven. This includes ensuite bathrooms for every resident bedroom in the rest home wing. Several residents in the dementia wings have shared toilets between two rooms. Where toilets are shared approval has been sought. 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>	FA	<p>At Brookhaven adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for Brookhaven residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<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</p>	FA	<p>Brookhaven laundry is undertaken both on site for resident's personal items in a dedicated laundry and off site for towels and sheets by a contracted provider. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of</p>

<p>being provided.</p>		<p>soiled linen. Care staff were observed and also described correct soiled linen handling techniques. Family members and 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. 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 resident and family formal and informal feedback, the internal audit programme and daily by Brookhaven staff and managers.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>GHG policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct Brookhaven in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 12 January 2011. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 18 April 2019. The Brookhaven orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs were sighted and meet the Ministry of Civil Defence and Emergency Management recommendations for the region. The needs of residents in the dementia service in an emergency were included in the plan. Water storage tanks are located around the complex. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Brookhaven call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p>

		Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff check the premises internally at night. The dementia wings are securely locked with restricted access. Security cameras and signs indicating their presence are placed in several locations throughout the complex. The cameras record activity and are monitored from the facility managers office.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All Brookhaven residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and one rest home bedroom has a door that opens onto an outside garden. Heating is provided by electric panel heaters in residents' rooms, and ceiling mounted heat pumps in the corridors and communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	<p>The service implements an infection prevention and control 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 external specialists. The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted.</p> <p>The senior registered nurse is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results are reported monthly to the quality assurance manager and to the monthly staff and management meetings.</p> <p>The infection control manual provides guidance for staff on how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents.</p> <p>There is information that cover aspects of infection control for family/whānau and if they are unwell, it is recommended that they do not visit the service. During higher risk times of community infections</p>

		<p>and winter months notices are placed at the door to remind people not to visit if they are unwell. There is sanitising hand gel at the entrance and throughout the service. Hand washing and sanitiser dispensers are readily available around the facility.</p> <p>There was an infection outbreak from 30 May 2019 to 28 June 2019 and this was managed according to the required standards. Notification to the local district health board was completed in a timely manner and records were sighted.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control coordinator (ICC) has appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control.</p> <p>Additional support and information is accessed from an external infection control agency, the infection control team at the DHB and the GPs as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by the organisation with advice from external specialists. Policies were last reviewed in January 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. Staff interviewed verified knowledge of infection control policies and practices.</p>
Standard 3.4: Education	FA	Staff education on infection prevention and control is conducted by the

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>ICC and other specialist consultants. The infection control coordinator attended infection prevention and control training conducted by an external consultant to keep their knowledge current. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included the GPs, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</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>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. GPs are informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</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>The organisation's 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 for Brookhaven staff. Staff reported the facility is restraint free and it is seven years since a restraint was used for a resident at Brookhaven. The restraint coordinator provides support and oversight for enabler and restraint management and demonstrated a sound understanding of the organisation's policies, procedures and practice and his role and responsibilities.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers, which staff are aware must be the least restrictive and used voluntarily at a resident's request.</p> <p>The restraint coordinator described that restraint can be used as a last resort when all alternatives have been explored and that this would</p>

		<p>trigger a referral for assessment. This was evident on review of the restraint approval group minutes, and from interviews with staff.</p> <p>New Provider Interview September 2019:</p> <p>The prospective new owner confirmed they are versed in their responsibilities regarding restraint minimisation and safe practice.</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)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>A safe medication management system was observed. Indications for use were noted on ‘as required’ medications, allergies were clearly indicated, and resident photos were current. Administration records were maintained, and drug incident forms completed in the event of any drug errors. All medicines were reviewed every three months for rest home and dementia level of care residents or as and when necessary.</p> <p>The medication records and associated documentation was in place. Medication reconciliation is conducted by the registered nurses when a resident is transferred back to service. The RNs check medicines against the prescription.</p> <p>The service does not keep any vaccines.</p> <p>An improvement is required to ensure expired medications are removed from stock and circulation.</p>	<p>All as required (PRN) medicines held in stock had expired and were still being administered.</p>	<p>Provide evidence that all as required (PRN) medicines held in stock are current and safe to use.</p> <p>90 days</p>

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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.