

Heritage Lifecare (BPA) Limited - Avondale Lifecare

Introduction

This report records the results of a Certification Audit; Partial 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 (BPA) Limited

Premises audited: Avondale Lifecare

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 12 November 2019 End date: 13 November 2019

Proposed changes to current services (if any): A reconfiguration to change the remaining 14 rest home level beds to dual purpose beds was undertaken with this certification audit. Sixteen dual beds are already available in this area of the facility.

Total beds occupied across all premises included in the audit on the first day of the audit: 65



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Avondale Lifecare provides rest home, secure dementia and hospital level care for up to 67 residents. The service is operated by Heritage Lifecare Limited and managed by a care home and village manager. The care home and village manager is supported by the clinical services manager. Residents and staff spoke positively about the care provided.

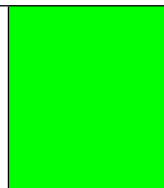
This certification and partial provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the District Health Board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, managers, staff, contracted allied health providers and a general medical practitioner.

The partial provisional audit was a reconfiguration to change 14 rest home level beds to dual beds. Sixteen dual resident beds are already available in this area of the facility.

Two areas have been identified in this certification and partial provisional audit as requiring improvement in relation to staff recruitment, the capacity of the current dining and lounge areas to accommodate an increased number hospital level residents with the proposed changes.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.



Standards applicable to this service fully attained.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. Residents' choices are respected including via the development of end of life care plans.

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.

There are processes in place to facilitate meeting the needs of residents who identify as Māori. Services are provided in a manner that respects residents' individual 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 to support best practice and meet residents' needs.

A complaints register is maintained with complaints resolved promptly and efficiently by the facility manager. Compliments are shared with the staff.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and beliefs of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

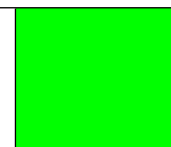
The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families/whanau. Adverse events are documented with corrective actions implemented. Actual and 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 managed effectively. A systematic approach to identify and deliver ongoing training supports safe service delivery and included annual staff individual performance review. Staffing levels and skill mix have recently been reviewed and a roster system is in place.

Residents' records are documented in a timely manner, in accordance with current accepted standards and are stored securely.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

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

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

Information is obtained about residents' interests and social history. Two staff facilitate the activities programme with input from a diversional therapist.

Medicines are stored securely 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. Avondale Lifecare has a registered food safety plan and food services are provided in accordance with the plan. Residents and family members verified satisfaction with meals.

Safe and appropriate environment

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

Waste and hazardous substances are managed effectively by maintenance staff. All clinical and non-clinical staff use personal protective equipment and resources. Chemicals, soiled linen and equipment are safely stored. Cleaning is undertaken onsite and is evaluated for effectiveness. The laundry is currently managed off-site.

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Five enablers were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is

voluntary for the safety of residents in response to individual requests. No restraints were in use. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme led by a designated registered nurse aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is available when needed.

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

The infection surveillance programme is relevant to the service setting and results are communicated appropriately.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	1	1	0	0
Criteria	0	91	0	1	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Avondale Lifecare has 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 in ongoing training, as was verified in training records and human resource records sighted.</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>The clinical services manager, registered nurses, general practitioner and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained for new residents using the organisation's standard consent form. This includes for outings / transport, release of health information, photographs, medical treatment and medication administration. Written consent for influenza vaccination was present in applicable residents' records. One resident has documented their intention to donate their body to a medical school. This is documented in the resident's care plan and an acknowledgment letter with some additional information from the applicable education institute is on file.</p> <p>Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Copies of enduring</p>

		<p>power of attorney (EPOA) and welfare guardian documents are sought, and copies kept on file. Documentation is available verifying that the EPOA document has been activated for all residents currently in the secure dementia unit. Care staff working in the secure dementia unit were aware of the name of the EPOA for each resident and contacted the EPOA when requests for information or requests to take a resident on an outing was received from any person other than their EPOA. These discussions and the outcomes were documented in sampled files and observed during audit.</p> <p>Residents were also encouraged to detail their wishes in regard to escalation of clinical care (eg, cardiopulmonary resuscitation and transfer to the district health board hospital) where applicable. Advance care plans (My Voice) documents have been completed by some residents and are on file. Palliative initiative outcome (POI) documents have been developed with some residents and families. Residents' choices and associated documentation have been reviewed at least annually for competent residents or following a significant change in health status. The resident's wishes are communicated to staff.</p> <p>Staff were observed to gain consent for day to day care activities. Participation in activities is voluntary.</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, a discussion occurs with the resident and family about the Code and Advocacy Service. Posters and brochures related to the Code and Advocacy Service were also displayed in the facility. Family members and residents spoken with on this topic were aware of the Advocacy Service, how to access this and their right to have support persons. Family are welcome at any time to visit with residents. Staff verified that family members are welcome to visit and are encouraged to support the resident in making choices and communicating their needs.</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, activities, and entertainment (refer to 1.3.7). Staff ensure residents are ready in time for any planned outings or visits.</p> <p>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 can come at any time. Family members are encouraged to accompany the resident to external health appointments. If unable to do so, the resident is accompanied by a staff member.</p> <p>Family members confirmed they were comfortable in their dealings with staff.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints and concerns 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 eight complaints had been received from November 2018 to November 2019 and that actions taken through to an agreed solution are clearly documented and completed within the required timeframes. All complaints are effectively closed out. The complaints register is maintained electronically by the care home manager and village manager. Staff education is provided on complaints management and all staff interviewed confirmed a sound knowledge and understanding of the complaint process and what actions are required. There have been no complaints received via the Health and Disability Commissioner (HDC) since the previous audit. Many letters and cards are received with compliments from families/whanau and residents and these were displayed for staff to read.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through discussions on admission and via posters / pamphlets displayed in the rest home. The Code is displayed in English and Māori. Information on advocacy services and complaint / feedback forms are readily available to residents and family members.</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.</p> <p>Staff were observed to maintain residents' privacy throughout the audit.</p> <p>Residents are encouraged to maintain their independence by attending community activities where able. Visitors are welcomed. Care plans included documentation related to the resident's individual abilities, and strategies to maximise independence.</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 care plan. Residents and family members interviewed verified the resident's individualised needs are met.</p> <p>Staff understood the service'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 as part of the ongoing education programme. Residents and family members interviewed were complimentary about staff and had no concerns about how staff treated, interacted or communicated with the residents, other</p>

		staff, and family members.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	At least one resident identifies as Māori. Residents are asked about any individual values, beliefs and needs they have, and these were documented to ensure the needs of the resident were communicated and met. Policy details the principles of the Treaty of Waitangi and these were incorporated into day to day practice, as was the importance of whānau. Support and specific guidance on culturally appropriate care is available via the 'Tikanga' easy reference flipcharts which were present in all staff office areas.
<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>	FA	Residents and family members verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed and the care plans are signed by the resident and/or designated next of kin. In the sample of care plans sighted, there was information about residents' individual needs including (but not limited to), culture, language spoken, clothing / appearance, dietary needs, and religious beliefs / faith.
<p>Standard 1.1.7: Discrimination</p> <p>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.</p> <p>The induction process for staff includes education related to professional boundaries and expected staff conduct / behaviours. The organisation's expectations related to staff conduct are also clearly detailed in staff employment contracts present in all staff files sampled and in the 'Heritage Way' document that is reviewed and signed by staff at employment.</p> <p>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</p> <p>Consumers receive services of</p>	FA	The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, a dietitian, wound care specialist, mental health services for older persons when clinically appropriate and agreed by the resident/enduring power of attorney (EPOA). The

<p>an appropriate standard.</p>		<p>general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to specialist feedback received.</p> <p>Staff reported they receive regular education that is relevant to their role and responsibilities.</p> <p>Other examples of good practice observed during the audit included the use of a comprehensive range of assessments to monitor residents' progress, six monthly multidisciplinary team meetings, the move to an electronic medicines management system (refer to 1.3.12), and the frequent use of pressure relieving mattresses and cushions for residents at risk of developing pressure injuries, and the use of sensor mats for residents at risk of falling. The service is trialing specific food items provided by an external supplier as part of a programme to try and optimise the most at risk resident's nutritional intake (refer to 1.3.13).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. A family communication record is maintained in each resident's individual file.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. This was supported by documentation of applicable events in the residents' records reviewed.</p> <p>Interpreters are obtained if required. The clinical services manager cannot recall an occasion in recent months where an interpreter service was required. For the current residents with limited or no understanding of English, staff advised there are staff currently employed at Avondale Lifecare that can converse in the resident's first language.</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 Avondale Lifecare strategic and business plan was reviewed. The business plan, which is reviewed annually, outlines the values, philosophy, scope, direction and goals of the organisation. The document described annual and longer term objectives and the associated operational plans. The 2019/2020 business plan reviewed outlines service specific goals to achieve. A sample of quarterly reports to the support office showed adequate information to monitor performance is reported including financial performance, emerging risks and any issues.</p> <p>The service is managed by an experienced care home and village manager who holds relevant management qualifications and has been in this role for two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The care home and village manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency by attending study days at the DHB and training provided by Heritage Lifecare Limited (HLL).</p>

		<p>The clinical services manager (CSM) commenced in this role one week prior to the audit; however, has been the unit coordinator for one year before applying for this position. The regional quality manager was present for this audit in an advisory and supportive role.</p> <p>The service holds contracts with the district health board for hospital services (medical and geriatric), rest home, respite care, secure dementia care, hospital and long term chronic health (LTCH). On the day of audit, 65 residents were receiving services under the contract; 13 rest home, 38 hospital; 14 secure dementia level care and two long term chronic health care (LTCH) residents who are both under 65 years of age and are included in the rest home numbers.</p> <p>Partial provisional: The care home and village manager interviewed stated that sixteen of the beds in the rest home are currently hospital level care and the remaining fourteen when approved will be dual purpose beds. Village residents are given priority if requiring a bed within the facility however no beds are kept available.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence of the care home and village manager, the CSM carries out all the required duties under delegated authority. Full support of the facility administrator is always available for advice and support. When the CSM is away the unit manager (yet to be appointed) will cover any clinical issues that may arise. A recruitment process is underway to recruit to this position. Staff interviewed stated that the current arrangements work well.</p> <p>Partial provisional: Recruitment is underway to appoint a new unit manager as the CSM was previously in that position until the recent changes occurred.</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>The organisation (HLL) has a planned quality and risk system and plan dated March 2018 to March 2020 that reflects the principles of continuous quality improvement. This includes the management of accidents and complaints, audit activities, health and safety, resident satisfaction surveys, monitoring of outcomes, clinical incidents including infections and pressure injuries. The care home and village manager ensures the goals set for the service are reported on in regard to progress against the set goals in the weekly reports and monthly communications cover sheet to the national support office.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the head of department meetings (clinical, health and safety, maintenance, and kitchen staff attend these meetings monthly) and monthly quality/staff meetings. The registered nurses also hold monthly meetings. Staff interviewed reported their involvement in quality and risk management through audit activities, weekly memos and their regular staff meetings. The 2019 audit schedule was available and reviewed. Relevant corrective actions are developed and implemented to</p>

		<p>address any shortfalls. Resident and family satisfaction surveys are completed at least annually; last in May 2019. Feedback was positive and a few negative points were actioned for improvement.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements including references to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. This is completed at support office.</p> <p>The care home and village manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The care home and village manager was familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. The incident/accident is also recorded in the resident's progress records, mentioned at handover, and if needed, the care plan was updated. All serious incidents/accidents are reported to the RN on duty before the end of the shift. There are policies and guidelines for incident/accident management to guide staff which provides useful information on the response to different types of events, including falls, abuse, infections, damage to property/equipment, security and health and safety issues. A sample of incident 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 categorised, analysed and reported to management. An event log is maintained by the care home and village manager.</p> <p>The care home and village manager described essential notification reporting requirements including pressure injuries. There have been four section 31 notices since October 2018 until 12 November 2019 (the date of this audit) reported to the support office. Two Section 31 notices were completed in relation to RN cover of the facility and two for residents who went missing from the dementia service, on different days. The care home and village manager and/or clinical services manager sends the Section 31 notices to the Regional Quality Manager at support office and then they are forwarded to the appropriate agency. These are also reflected and included on the clinical indicators reported monthly by the care home and village manager including, unintentional weight loss, falls with and without injury, skin tears, behavioural incidents, medication errors, property loss and security issues. A summary is forwarded to the support office. The incident forms are filed in the individual resident's record.</p>
<p>Standard 1.2.7: Human Resource Management</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process included referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. Qualifications of trained staff and allied</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>health professionals including the registered nurses, general practitioners, one enrolled nurse, physiotherapist, pharmacists, dietitian, podiatrist and the pharmacy licence to operate are reviewed annually. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Job descriptions were sighted for each staff member depending on the role they undertake. Staff records reviewed showed documentation of completed orientation, a verbal review following orientation and a performance review after one year. A schedule was reviewed for completing the required annual staff performance appraisals. Appraisals were current and up-to-date.</p> <p>Continuing education is planned annually including mandatory requirements. An educational plan and staff training record spread sheet was sighted. Care staff (35) in total have completed a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Nineteen staff have completed the required training to provide care to the residents in the dementia service. There are seven registered nurses (including the CSM), four of whom are currently maintaining their annual competency requirements to undertake interRAI assessments. The regional quality manager (RN) is able to provide support and advice as needed. Thirty of seventy staff have completed first aid training with a recognised provider and have current first aid certificates.</p> <p>Partial provisional: The service is actively recruiting for RNs nationally and internationally with the assistance of a contracted bureau of choice. Two bureau representatives were interviewed during the onsite audit. An interview with a prospective RN had been arranged for the next day.</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>PA Moderate</p>	<p>There is a documented allocation of staff/duty rosters policy to guide RNs and the CSM. An electronic tool based on the indicators for safe staffing is used by the care home and village manager. The rosters reviewed cover 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call system is in place and staff interviewed reported that good access to advice is available when needed. Care staff interviewed reported that teamwork was encouraged. Residents and family members interviewed supported this. Staff are replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage. The service is covered and well supported by the care home and village manager working Monday to Friday 8am until 5pm and the CSM working Monday to Friday 8am to 5pm. The unit coordinator position (RN) is currently vacant and more RNs and care staff are needed for the nature and size of the facility and the increase in hospital level care residents. This was supported by staff and family members interviewed.</p> <p>Partial provisional: An increase number of two to three RNs and additional care staff are to be employed to ensure the identified needs of residents will be able to be met in particular if the residents admitted are</p>

		requiring hospital level care. The reconfiguration is to change the remaining fourteen rest home level beds to dual purpose beds.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was completed in the residents' files sampled for review. Clinical notes were current and integrated with allied health service provider notes. There is documentation in individual residents' files by registered nurses. The RNs document daily for residents receiving hospital level care and at least every three days for residents receiving rest home and dementia level of care. There is a schedule to identify which shift the notes are to be routinely documented. Documentation is more frequent where indicated/required. Health care assistants document interventions provided at least daily and complete monitoring records as relevant for each resident every shift.</p> <p>InterRAI assessment information is entered into the Momentum electronic database. The progress notes reference the GP review and any subsequent changes in the plan of care. Records were legible with the name and designation of the person making the entry identifiable. Printed copies of laboratory results are in residents' files. An electronic medicines management system is in use. All applicable staff have unique passwords and log-ons.</p> <p>Archived records are held securely on site and are readily retrievable.</p> <p>The clinical services manager is aware of the time period that residents' files are required to be held for.</p> <p>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>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 as rest home, or secure dementia, or hospital level of care. A document from a medical specialist verifying the resident requires secure dementia level of care is present in all sampled resident files in the secure dementia unit.</p> <p>Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written and verbal information about the service and the admission process. The organisation seeks current information from the applicable clinical teams and NASC to ensure the prospective residents' needs can be safely met. The care home and village manager and the clinical manager are responsible for managing residents' enquiries, with the assistance of an administrator. For all sampled residents in the secure dementia unit, the EPOA has signed the admission agreement. Copies of the EPOA agreement and records verifying the activation of EPOA are in the records for the residents receiving dementia level of care whose records were sampled.</p>

		<p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission.</p> <p>All residents' files reviewed contained completed demographic details and appropriate assessments. The HLL admission agreement uses the New Zealand Aged Care Association admission agreement. Service charges comply with contractual requirements.</p> <p>Information on the services at Avondale Lifecare are communicated via the NASC service, Eldernet website, and word of mouth.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses a documented system to facilitate transfer of residents to and from acute care services, and ensure relevant information is communicated. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example of this was sighted in records related to a resident transferred to and from the DHB hospital for acute care.</p> <p>Family members interviewed reported being kept well informed of any changes in the resident's condition and escalation of care with consideration of any advance directives the resident has put in place prior. Where there has been a significant change in the resident's condition, the GP meets with the resident and family to discuss and determine the ongoing plan of care. This includes identifying when the resident's care is to be focused on ensuring comfort, or whether the resident or family wants the resident to be transferred to the acute services in the future and if so for what events / symptoms. The resident's and family members' choices are documented and communicated effectively to staff. Where residents care needs change, the resident is referred to the funder for reassessment of the resident's level of care. Where the resident moves within Avondale Lifecare to a different level of care, this is documented and the staff in the receiving unit are given an appropriate handover.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy was current and included required components to meet these standards. An electronic medicines management system is used. Standing orders are not used.</p> <p>A safe system for medicine management was observed on each day of the audit. The RN in one unit, and the HCA in the secure dementia unit were observed and demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Completed competencies were sighted and included where applicable 'Niki T' syringe driver competencies. The medicine records</p>

		<p>for 18 residents were reviewed. These were legible and each entry has been signed by the GP. The date medicines commenced was noted. Discontinued medicines have been dated and signed. Indications are noted for pro re nata (PRN) medicines. Assessments for medication sensitivities and allergies was noted. Administration records are clear. There is a photograph of the resident on their individual medicine chart.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. An RN checks the contents of the medicine supplied against each resident's individual medicine record before putting the medicines into use. The RN and HCA were observed to check this information again at the time of administration. All medications sighted were within current use by dates. Pharmacist input is provided on request.</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 stock checks and accurate entries. The six monthly quantity stock count had been completed. There were no vaccinations or other medications that require a cold chain process to be implemented. All vaccines are brought onsite when required by the vaccinator. Prior consent is obtained for the administration of any vaccine. The medications that require refrigeration are stored appropriately. The temperature of the refrigerator is monitored daily and was within the required temperature range.</p> <p>There were two residents self-administering medications at the time of audit. Processes were implemented to ensure each resident was safe to do so, including obtaining prior approval from the GP. One resident interviewed demonstrated how the medicines were securely stored in their room and could articulate what medicine was taken, when and for what purpose.</p> <p>There is an implemented process for the reporting, management of, and analysis of medication errors.</p> <p>Residents and family members are informed of medicines at the time of administration and any changes in medications that have been prescribed.</p> <p>Partial provisional audit: The existing medicine management system will continue to be utilised for all residents regardless of their level of care.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food services are provided on site by employed staff. There are two cooks. One works weekdays and one works weekends. They are assisted by kitchen assistants. The main meal is served at lunchtime.</p> <p>Applicable staff have completed food safety training. The menu is a four-week seasonal rotating menu. The current summer menu has been reviewed by a qualified dietitian and approved as being appropriate for the residents. The service has an approved food safety plan. Implementation of the food service plan has been subsequently verified by Auckland City Council and records sighted. All aspects of production, preparation, storage and disposal comply with current legislation and guidelines.</p>

		<p>A nutritional assessment is undertaken for each resident on admission to the facility by nursing staff and a dietary profile is developed. The personal food preferences, any special diets, cultural needs, and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs, is available. Nutritional supplements are also available and used where clinically indicated / prescribed. An external food product is being trialled. These food items come pre-made with a focus on nutritional quality not quantity for at risk residents. This is being trialled to see if it enhances the nutritional status of applicable residents.</p> <p>Residents' satisfaction with meals was verified by resident and family interviews.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner. Where preferred, residents can eat their meals in their room and staff assistance is also provided as required.</p> <p>There is adequate food supplies and special diets and/or supplementary foods are catered for appropriately. Food is available 24 hours a day in the secure dementia unit.</p> <p>Partial Provisional Audit: The existing process to identify and communicate residents' dietary needs will continue regardless of the resident's assessed level of care. The cook advised the service already provides a range of textured meals for residents and can meet the needs of changing residents using existing processes and within the current staffing resource. There is not sufficient space in the applicable units dining room for an increased number of hospital level care residents if they are in wheelchairs or recliner chairs. Refer to area for improvement raised in criterion 1.4.5.1.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised along with the prospective resident and family, in order to support them to find an appropriate care alternative. Alternatively, the prospective resident is placed on a wait list if urgent admission is not required.</p> <p>If the needs of a resident change and they are no longer suitable for the current services provided, the clinical services manager advised a referral for reassessment to the NASC is made and examples of this were sighted. Avondale Lifecare can provide care for residents who have changing needs including requiring secure dementia or hospital level of care.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, wound assessments, continence, and nutritional screening, to identify any deficits and to inform care planning. Allied staff and the general practitioner document an assessment at the time of each</p>

<p>are gathered and recorded in a timely manner.</p>		<p>consultation.</p> <p>The sample of care plans reviewed had an integrated range of resident-related information. All residents had a current interRAI assessment completed by one of the seven registered nurses (including the CSM) with current competency for conducting interRAI assessments. Residents and families confirmed their involvement in the assessment process and residents' goals are clearly documented.</p> <p>Prior to the interRAI assessments being reviewed / updated, members of the multidisciplinary team review the resident's current condition. The healthcare assistants (HCAs), activities staff and resident / family are consulted about changes in the resident's health or function and the resident's progress to achieving their current goals and review any reported events / incidents that have occurred in the last six months. The six monthly multidisciplinary (MDT) review is documented on a specific template in addition to the updating the interRAI assessment documents. The MDT reviews were current for all applicable residents who have been at Avondale Lifecare for six months or longer and whose records were sampled.</p> <p>There is a resident social profile assessment completed which is used to inform the resident's 'map of life' and activities plan.</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>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. The physiotherapist documents a mobility / transfer plan for residents. Any change in care required is documented and verbally passed on to relevant staff.</p> <p>Residents and families reported participation in the development and ongoing evaluation of care plans. Short term care plans were appropriately developed in sampled files for new issues including wounds, increased pain, a pressure injury, weight loss, infections or other acute care needs. Health care assistants interviewed confirmed they are advised of changes in residents' care plans in a timely manner. For staff quick reference, a list is present in each unit detailing residents with a current short term care plan in use, the date the short term care plan commenced, and for what issue. The RN documents when the short term care plan has been discontinued.</p> <p>Individualised care plans provide guidance for staff on de-escalation and managing specific behaviours for applicable residents including residents in the secure dementia unit.</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 the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Records are made of the residents that need to be seen by the GP each visit. This included for routine reviews or if there were any issues requiring follow-up or new concerns. Copies of laboratory results are reviewed and signed by the GP. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was 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. Air mattresses and sensor mats are used for 'at risk' residents.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by two activities staff. One activities assistant works weekdays, and another is rostered up to three shifts, Wednesday to Friday, and on the weekend days with shorter hours. The activities staff assist in taking residents to offsite appointments if family are unable to do so. The activities assistant that works the weekend has been on leave and was not consistently replaced. When there is one activities staff member on duty the activities person visits each unit; however, there is limited time in each unit. A trained diversional therapist (DT) who has the national Certificate in Diversional Therapy is assisting / mentoring the activities staff with resident assessment documentation and activities planning processes. The DT is on site between two and four hours a week.</p> <p>While staff in the secure dementia unit provide some additional activities during the day with residents, these were 'repetitive' and with the exception of outings are not that stimulating according to family members interviewed, with prolonged periods of sitting. The care home and village manager has recently introduced additional care staff hours in the dementia unit late afternoon to assist with activities in the management of the impact of residents that are 'sundowning'.</p> <p>There are limited activities available for residents receiving hospital level care as observed during audit. The activities staffing resource requires review for the existing resident care needs as well as the future needs of the service with the prospective increase in hospital level of care residents. This is included in the area for improvement raised in 1.2.8.1. The activities coordinators have a range of appropriate supplies available to them and have made recent purchases of new resources.</p> <p>A social assessment is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements and a 'map of life' developed. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful and specific to the residents of all ages. Residents recreation needs are reviewed as a part of the MDT meeting. Records of attendance at activities are maintained. Residents' birthdays are celebrated with a cake and 'goody bag'.</p> <p>The activities that were provided reflected residents' goals, ordinary patterns of life and include normal</p>

		<p>community activities. Residents from the rest home, hospital and dementia unit come together for some activities including the visiting entertainers. The activities programme is displayed for the residents and family. Regular outings occur which are enjoyed by the residents interviewed. Participation in the activities programme is voluntary. There are some residents who choose not to participate but prefer to engage in personal activities of their choice.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The GP and allied staff document their assessments and the ongoing plan of care during each consultation.</p> <p>Formal evaluation of care plans occurs every six months in conjunction with the six-monthly MDT meeting and interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and the use of short term care plans. Examples of short term care plans being regularly reviewed by the RNs were sighted. Progress was evaluated as clinically indicated for wounds, infections, and weight loss. Residents are referred to the dietitian for review if there are concerns about their weight. When necessary, and for unresolved problems, long term care plans are added to or updated. The lifestyle care plans of each resident is reviewed at least every six months or sooner where applicable. Wound care charts are used to record the condition of the wound at each assessment and detail any interventions provided.</p> <p>The results of laboratory investigations and analysis were present in residents' files sampled. At least monthly weight and vital signs were recorded for each resident, or sooner where requested / indicated. The results are monitored over time and variances reported to the GP and dietitian where applicable. Other evaluation tools in use included fluid balance charts, behavioural charts, pain assessments using the Abbey pain scale, blood glucose monitoring, turning charts, and a monitoring chart for residents receiving Warfarin. The assessment forms have been completed consistently by staff where appropriate / clinically indicated in sampled records.</p> <p>Neurological observations were undertaken for at least a 12-hour period in sampled files after any unwitnessed fall or where there is concern that a resident may have hit their head.</p> <p>Records of attendance / participation in the activities programme are maintained.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers, or their refusal of referral offer is noted.</p> <p>If the need for other non-urgent services are indicated or requested, with written referrals made to the applicable health professional. The decision to refer the resident was documented in the applicable residents' files sampled and discussed with the resident and / or family members prior. Examples were</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>sighted of residents referred to the dietitian, NASC service, wound care nurse specialist and mental health for older persons service. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste, 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. A spill kit was available.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. There was evidence of a large clean out of order stored equipment awaiting collection by a contracted waste management contractor for recycling and this was moved at the time of the audit.</p> <p>Partial provisional: There are adequate supplies of personal protective equipment available for staff with the proposed change to dual purpose beds in the rest home.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 29 June 2020) was publicly displayed.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities were fit for their purpose and maintained. Handrails are in place in the hallways. The building is all on one level. There are safe level pathways around the facility.</p> <p>The testing and tagging of electrical equipment and calibration of biochemical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to all the resident groups and the setting. The gardens are maintained. A separate garden area extends out from the dementia service with seating available. Level pathways and a perimeter fence for safety is in place. Key pad access to doors was in place for the dementia service.</p> <p>Residents confirmed and were observed demonstrating they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they were happy with the environment. The facility is accessible to meet the equipment and mobility needs of the residents.</p> <p>Partial provisional: There are adequate hoists in all areas of service delivery. Wheelchairs and walking</p>

		aids are available for the proposed reconfiguration. Storage is available when needed.
<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>The facility is divided into three wings or service areas. The rest home and hospital services have ensuite bathrooms. There are three extra toilets in the rest home if needed. Only two rooms in the hospital require residents to share a bathroom. All rooms have hand basins except for the dementia service. All other toilets and showers are in close proximity to the residents' rooms in all wings where needed. Appropriately secured and approved handrails are provided in all bathrooms and other equipment and accessories are available to promote residents' independence. Facilities are available for staff and visitors.</p> <p>Partial provisional: No changes are required for the reconfiguration to 14 dual purpose beds.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Bedrooms provided are single or double accommodation. There are nine generous sized double rooms in total. Each resident's room and all service areas have a call bell system in place. All rooms were personalised with furnishings, photographs and other personal items being displayed. In all service areas visited there was adequate space to store total mobility scooters, hoists, shower chairs, wheelchairs and walkers.</p> <p>Partial provisional: There are adequate bathrooms and showers in communal areas and hand basins in all rooms designated for dual purpose beds. All rooms have hand basins. All bathrooms in the hospital and rest home can accommodate hoists if required.</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>	PA Low	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are of adequate size in the hospital and dementia services and enable easy access for residents and staff. Furniture sighted was appropriate to the setting and residents' needs. There is a separate dining and two lounge areas in the rest home which accommodates most of the residents but with additional hospital level residents this would not be suitable unless another lounge is used for mealtimes. There are a few small lounges throughout the facility which can be utilised as a family/whanau lounge or for private conversations if needed.</p> <p>Partial provisional: The lounge dining areas in the current rest home/hospital are not adequate to accommodate residents safely to meet their relaxation and dining needs. Planning is required to ensure adequate space is available at mealtimes and for activities and relaxation. Sixteen residents in the rest</p>

		home/hospital are already hospital level care residents.
<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>The laundry is undertaken off-site although a laundry room is available. The staff interviewed are fully informed of their respective duties and have been in their roles for many years. There is one laundry person on duty each day of the week. Five staff cover the laundry and the cleaning. The staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and the handling of any soiled linen. The laundry person collects the soiled laundry from the three wings and the bags are prepared for collection by the contracted service provider. Clean linen is delivered at the same time. Staff put all linen away in each service area. The only laundry washed on-site is the tea towels for the kitchen. Laundry is managed well and personal clothing is returned in a timely manner and laundry staff sort out personal clothing and deliver to the residents' room.</p> <p>Chemicals are stored in a locked cupboard in close proximity to the laundry and kitchen and were clearly labelled. A contracted service provider provides all chemical training for kitchen, laundry and cleaning staff. Training was verified in the training records reviewed.</p> <p>The cleaners store their trolley appropriately in the locked sluice room when not in use. A refillable chemical system is in place. Protective equipment and resources are provided with good stores available when needed. Two cleaners work each day seven days a week. Care staff assist as needed.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and temperature monitoring is managed effectively in collaboration with the maintenance staff and contracted service providers.</p> <p>Partial provisional: As additional hospital level services are provided the domestic/household staffing levels be adjusted to accommodate and manage increased laundry duties. Staff interviewed stated (staff collect linen from the wings and prepare linen bags of soiled linen for collection by contracted providers) and additional linen supplies will be required and will have to be put away by laundry staff.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service 15 March 2002. A trial evacuation takes place six monthly with an outcome copy sent to the fire service; the most recent training being held on 3 September 2019 and 9 October 2019. The orientation programme includes fire and security training. Staff interviewed confirmed awareness of the emergency procedures for all groups of residents including residents in the secure dementia service.</p>

		<p>Adequate supplies for use in the event of a civil defence emergency including water, food, blankets, radios, torches and gas barbecues were sighted and meet the requirements for the 65 residents and the local council in this region. Portable water and food is available for all emergencies. Water storage including a 900 litre tank is available. Emergency lighting is available and regular testing occurs. A generator would be hired if needed.</p> <p>The service has hot water supplies to the wings. The hot water is checked and monitored at the beginning of each month and recorded by maintenance staff. The temperatures meet the requirements and are safe.</p> <p>Training is provided to staff in relation to health and safety including emergencies, moving and handling and hazard training and this was sighted on the education plan.</p> <p>A call bell system is audited regularly and residents stated their calls to summon assistance are responded to by staff in a timely manner.</p> <p>Appropriate security arrangements are in place with a contracted security company and staff are also responsible for the doors and windows on the afternoon and night shifts. Security lights are attached to the building. There are no staff based at reception/main entrance after hours but staff will answer the bell if rung. Key pad access is available for the secure dementia service.</p> <p>Partial provisional: No changes will be required for the proposed reconfiguration.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Underfloor heating was maintained by the maintenance staff. Heat pumps have been installed in the offices. Rooms have natural light and opening external windows. All service areas were warm and maintained at an even temperature. This was confirmed by the residents and families interviewed.</p> <p>Partial provisional: No changes will be required in regard to natural light, ventilation and heating for the reconfiguration.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and</p>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors through the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by current infection control policies and procedures. The infection control programme is reviewed annually. There is signage on the front door alerting visitors not to enter if they are sick.</p> <p>Residents with a multi-drug resistant organism (MDRO) have this clearly detailed in their clinical records.</p> <p>Two designated registered nurses are responsible for coordinating the infection prevention and control</p>

<p>scope of the service.</p>		<p>programme with the support of the wider RN team. The role and responsibilities of the infection prevention and control (IP&C) nurses are documented. Infection control matters, including surveillance results, are reported monthly to the care home and village manager and clinical services manager and discussed in the regular staff meetings. The IP&C nurses were not on duty during audit. The clinical services manager provided all requested / required information.</p> <p>Staff and residents are offered an annual influenza vaccination. Completed consent forms were sighted.</p> <p>Staff interviewed understood their responsibilities to prevent the spread of infection. Appropriate personal protective equipment (PPE) was available and was observed to be in use. There have been no outbreaks of infection since the last audit.</p> <p>Compliance with key aspects of policy is monitored via the internal audit programme.</p> <p>Partial Provisional Audit: The existing infection control programme and associated process to identify and communicate residents' with infections will continue unchanged, and is not impacted by potential changes in the resident's assessed level of care.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The two IP&C nurses are registered nurses and are both new to the role of IP&C. The two IP&C nurses have completed the infection prevention and control e-learning programme 'learn online'. If required, expert advice can be sought from the community laboratory and/or the general practitioner, or public health service, or DHB nurse specialists, for example, a wound care nurse.</p> <p>The IP&C nurses have access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The CSM interviewed confirmed at interview the availability of resources to support the management of any outbreak of an infection should this be required. Emergency supplies of personal protective equipment was available.</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</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 current. A paper-based copy of all the policies are available for staff to access in a designated office.</p> <p>Care delivery, cleaning, and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good handwashing techniques and use of disposable gloves, as appropriate. Hand washing and sanitiser dispensers were available in designated areas around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

<p>in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The staff education plan includes infection prevention and control. This commences during orientation and has been continued in the ongoing education programme. Topics included food safety, continence management and was also included as applicable in other topics discussed. Records are maintained of all education provided. The education is provided by the infection control nurses, the clinical services manager or product representatives, or external consultants.</p> <p>Education with residents is generally on a one-to-one basis and has included aspects of personal hygiene, the benefits of the influenza vaccination, and the prevention of urinary tract infections or the treatment plan for new infections. Family members interviewed confirmed they have been informed of any infections their family member has developed and the treatment offered / provided.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for a long term care facility. This includes urinary tract infections, skin and wound infections, eye, ear, nose and throat infections, chest infections, multi drug resistant organisms, and some other infections. When an infection is identified a record of this is documented on the infection notification form by the RN who is responsible for the resident's care at the time of diagnosis, and also detailed in the applicable resident's file. The infection prevention and control nurses review all reported infections and maintain a record including the name of the resident, the type of infection, the results of laboratory investigations (if applicable), the treatment and the outcome. The GP interviewed confirmed being informed in a timely manner of residents with suspected infections. The residents' infections as detailed in the sampled residents' files have been included in the infection surveillance data in the month the infection was diagnosed. Residents and family members confirmed they are informed of all suspected or actual infections and the plan of care.</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 and benchmarked with other HLL facilities. There are documented definitions of infection for consistency.</p> <p>There have been no outbreaks of infection since the last audit.</p>
<p>Standard 2.1.1: Restraint</p>	<p>FA</p>	<p>Policies and procedures (reviewed October 2018) meet the requirements of the restraint minimisation and safe practice standard and provide guidance on the safe use of both restraints and enablers. The restraint</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>coordinator was available on the day of audit and provides support and oversight for enabler and restraint management in the facility. The registered nurse restraint coordinator interviewed demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities. A restraint audit was completed in October 2019 and education was provided on the 14 August 2019 with 16 attendees.</p> <p>On the day of the audit five enablers were in use. No restraints were in use or have been used for six months. Enablers were 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 is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, records reviewed and from interview with staff.</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 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA</p> <p>Moderate</p>	<p>Four weeks rosters were reviewed. The daytime shifts were covered adequately; however, the hospital currently has one RN at night and two care staff, one of whom is a ‘floater’ over the other services. The rest home wing, which has 16 hospital level residents and 14 rest home level care residents, has one caregiver at night and the secure dementia service one caregiver. Due to the layout and design of the building this staffing is not adequate for the changing over to dual purpose beds as discussed with the CSM and the care home and village manager.</p> <p>Two activities staff cover this area of service delivery. One diversional therapist (DT) works two days a week to update the activities plans. Additional recreational staff are required to cover the services when one is taken from the facility for outings or</p>	<p>The recruitment process for registered nurses and caregivers is underway. However, the allocation of staff on the roster does not reflect adequate cover for the rest home and hospital service on afternoon and night duty if the registered nurse is called away from the hospital to the rest home.</p> <p>Recruitment of additional care givers and registered nurses will need to occur prior to changing the current rest home level care beds to dual purpose beds. A higher level of</p>	<p>Adequate staffing is provided to meet the needs of the residents and to cover the proposed change to dual service beds.</p>

		appointments as needed.	<p>staffing will be required for increase of hospital level care residents when admitted or if rest home level residents needs change.</p> <p>When activities staff are away or taking residents to appointments, there is not always adequate cover provided for the recreational activity programme to be implemented.</p>	Prior to occupancy days
<p>Criterion 1.4.5.1</p> <p>Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.</p>	PA Low	<p>The access to the rest home/hospital dining is not large enough to accommodate all residents in this wing. The lounge is currently used to accommodate residents at meal times as well as the dining room. With the reconfiguration planned to change to dual purpose beds an additional area possibly will be required for dining and recreational purposes to meet the needs of hospital level residents especially for those residents requiring the use of wheelchairs.</p>	<p>The dining room in the rest home/hospital does not provide sufficient space to meet the dining and recreational needs of all residents. The lounge is currently used to accommodate residents at mealtimes. Consideration and additional planning is required if there is to be an increase in the number of hospital level care residents.</p>	<p>Access to adequate dining and recreational facilities in the rest home area is to be provided for all residents as required.</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.

No data to display

End of the report.