Heritage Lifecare (BPA) Limited - Flaxmore Care Home

Introduction

This report records the results of a Surveillance 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:	Flaxmore Care Home
Services audited:	Dementia care
Dates of audit:	Start date: 9 October 2020 End date: 9 October 2020

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 43

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Flaxmore Lifecare provides rest home dementia care for up to 48 residents. The service is operated by Heritage Lifecare Limited and managed by a care manager who has only recently taken on the role. The clinical services manager has recently resigned, and the new appointee is to take up the role in the near future. Families spoke positively about the care provided and residents said they are happy at Flaxmore Lifecare.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a nurse practitioner.

This audit identified five areas requiring improvement relating to complaints management, key elements of the quality and risk management system including measurements against the programme, staff training and documentation for the residents' activity programme. An area in relation to cleanliness of the environment that was identified as requiring improvement at the previous audit has been addressed; however, one in relation to staff performance appraisals remains outstanding.

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.		Some standards applicable to this service partially attained and of low risk.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

Staff and family members are familiar with processes around lodging a complaint. A complaint register process is established.

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.

The scope, direction, goals, values and mission of the organisation are described within a business plan. There is regular reporting to the governing body from the care facility. An experienced and suitably qualified person manages the facility.

The quality and risk management system is described within a comprehensive quality and risk management plan. This includes collection and analysis of quality improvement data, correction of shortfalls and identification of opportunities to make

improvements. Staff are involved and feedback is sought from families. Adverse events are documented with follow-up occurring. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures that support service delivery were current and reviewed regularly.

The appointment, orientation and management of staff are based on current good practice. A staff training schedule is in place and staff are encouraged to undertake additional education. Staffing levels and skill mix are adjusted to meet the changing needs of residents.

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.		Some standards applicable to this service partially attained and of low risk.

Residents of Flaxmore Lifecare have their needs assessed on admission by the multidisciplinary team. Shift handovers and communication reports guide continuity of care.

Care plans guiding resident care are individualised, based on a range of comprehensive and integrated clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and the family members of residents reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is provided by a recreation coordinator. Residents are provided with a variety of individual and group activities and links with the community are maintained. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents and their family members verified overall 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.		Standards applicable to this service fully attained.

There is a current building warrant of fitness. No modifications have been made to the buildings since the last audit.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. These cover the requirements of the standard, including assessment, approval, monitoring, evaluation and review of use within the quality system. There were no enablers or restraints in use at the time of audit. A strong focus on management of behaviours that challenge, and de-escalation

techniques supports the no restraint philosophy. Staff were aware that any use of enablers is voluntary and were familiar with the service provider's policies and procedures.

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.

Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	3	1	0	0
Criteria	0	34	0	4	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The complaints, concerns, and compliments policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The electronic complaints register reviewed showed that five complaints have been received since January and reflected some of the actions taken, through to an agreed resolution. A hard copy folder had three complaints with complete information about them. There were discrepancies between the complaints filed in the hard copy complaint register and the electronic version of the register. In addition, not all complaints discussed by staff during the audit had been recorded in one or other register and the number of complaints in the registers did not match the information in the quality indicator data forwarded to the support office. A corrective action has been raised in relation to these shortcomings. Action plans for various complaints on file were evident in conversations with the senior staff and in the quality and risk meetings reviewed. The care manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There are no complaints from the Health and Disability Commission that are currently open. Previous history regarding these was unknown by the new manager.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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. This was supported during review of completed accident/incident reports and in the communication forms in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. They also noted that not all family members want to be informed of incidents unless serious and this is recorded in the resident's record. The manager and senior staff know how to access interpreter services through the Nelson Marlborough District Health Board, although reported that to their knowledge this had never been required. Staff confirmed they have adapted communication processes with a person for whom English is a second language, and that their partner is used to help translate if they are not convinced the person fully understands. Clear instructions regarding communication are in the resident's record.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	A business plan for 2020 has six group overarching goals that cover finances, residents' and staff satisfaction, the provision of quality clinical care, health and safety, property, maintenance and promotion of Heritage Lifecare Limited (HLL). Business requirements and measures of success are documented against each goal. Facilities add their own goals and action plans within a separate business plan and the manager completes the reporting template on a monthly and quarterly basis. These reports have been maintained despite management changes. A Heritage Lifecare document called 'the Heritage Way' includes the HLL vision of being a significant provider of aged care services throughout New Zealand especially in the area of residential care for older people. Its overall mission is: 'the continued pursuit of excellence in care through monitoring, auditing, actioning and evaluation of services whilst respecting and valuing our residents, families and staff'. The organisation's commitment and ability to achieve its mission is dependent upon its five underlying values of integrity, respect and value, commitment, effectiveness, and efficiency. A sample of monthly reports sent from the business and care manager to HLL were sighted, as were examples of the quality indicator data provided to HLL each month. Both sets of reporting provide monitoring of financial reporting, emerging risks and issues of concern. A care manager who holds relevant qualifications and has been in the role for only four weeks is responsible for the management of Flaxmore Lifecare. This person managed the facility some years ago under a different management structure, has been responsible for other care homes and was a regional manager of several facilities. Responsibilities and accountabilities are reportedly defined in a job description and individual employment agreement, which were not viewed as the personnel file is held in the support office. The care manager confirmed knowledge of the sector, regulatory and reporting requirements. By chance, an operations manager was on site the day of audit and confirmed the skills and competence of the manager and noted these had already been proven in the person's first few weeks in the role. The service holds contracts with Nelson Marlborough District Health Board for dementia rest home level care, including respite care, under the Aged Related Residential Care (ARRC) agreement. Forty-three residents were

		receiving long term residential care services under the ARRC agreement at the time of audit.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes reviews on education, clinical issues, complaints, management of incidents, internal audit activities and checklists, infections and monitoring of a wide range of clinical outcome data. Quality indicator data, which is inclusive of incident reporting is being collected on a monthly basis and forwarded to the HLL support office. There is limited evidence to demonstrate this is being fully analysed at facility level in a manner that would enable quality improvement or corrective action. Registered nurse and staff meeting minutes demonstrated that clinical risks are being identified and actioned in a timely manner; however quality and risk meetings have been repeatedly cancelled and the two sets of meeting minutes viewed for the past 10 months primarily focus on clinical risk, rather than being inclusive of wider organisational requirements. Staff reported that in the past they were involved in internal audits and received feedback from incidents/accidents and were advised of follow-up taken. They are required to sign new policies and procedures to confirm they have read them. Corrective actions are being developed and followed through for the aspects of the quality and risk management system that are being maintained. According to the care and facility manager and the registered nurse, a family satisfaction survey was completed several months ago; however, there was no evidence of this available and nor was there any analysis of the information available. The internal audit schedule has not been maintained. Shortfalls regarding implementation of the quality and risk management system have been raised for corrective action within the relevant criteria. It is acknowledged that the facility has had an interim manager for some months, that Covid-19 has added pressures on implementation of the quality and risk system and that the new care and facility manager has only been in the role for four weeks. The new manager expressed a commitment that one of their priorities is to return the quality and risk management system to full function as soon as possible. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. They are based on best practice and were current. The document control system ensures a systematic and regular review process every three years, referencing of relevant sources, approval, distribution and removal of obsolete documents. The care and facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The care and facility manager was familiar with the Health and Safety at Work Act (2015) and has implementing requirements. Updated hazard registers are available.
Standard 1.2.4: Adverse Event	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, open disclosure is occurring, incidents are investigated, where applicable action

Reporting 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.		plans are developed, and the actions are being followed-up in a timely manner. Adverse event data is collated and reported to HLL support office as part of the monthly reporting of quality indicator data. Analysis is incomplete as raised for corrective action in criterion 1.2.3.7. Staff accidents and incidents are recorded separately and managed appropriately. The care manager described essential notification reporting requirements. They advised that as per their understanding, other than a hip fracture that did not require reporting, there have been three notifications of significant events made to the Ministry of Health since the previous audit, with two of these being people absconding and one police callout. Other relevant stakeholders including older persons mental health and the needs assessment services had been notified as required.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, an initial interview, police vetting and validation of qualifications and practising certificates (APCs), where required. A folder of APCs for health professionals who provide input into residents in Flaxmore showed all as being current. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation programmes that are individualised according to the person's position, are comprehensive and include all necessary components relevant to the role. Staff reported that the orientation process prepared staff for their role and the timeframe may be extended if indicated. Staff records reviewed showed documentation of completed orientation. Continuing education, including mandatory training requirements, is planned on an annual basis according to a schedule supplied by the Heritage Lifecare support office. Staff attendance at training is recorded and individual staff training records are available. Other than interruptions to the training schedule as a result of the impact of the Covid-19 pandemic, the staff education programme has been maintained with the manager describing how staff will be brought up to date with the few that are overdue. Additional training on hand hygiene and infection prevention and control has been provided. 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. However, the contractual requirements around education specifically for staff working in a dementia care area have not been upheld with many staff not having completed the requirements. This has been raised for corrective action. There are sufficient trained and competent registered nurses (two of three) who are maintaining their annual competency requirements to undertake interRAI assessments. Training records also confirmed other competencies for registered nurses are being completed as required. Changes in management, and several months with only a relief manager in place, has meant staff

		performance appraisals have still not all been completed within the required timeframe and the previously raised corrective action remains open.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). This is complemented by a staff rostering policy. A review of rosters and conversations with the care manager confirmed that the facility adjusts staffing levels to meet the changing needs of residents. The care manager confirmed that registered nurses may increase staffing levels or extend a shift based on clinical decision-making skills, with an example being during a norovirus outbreak. Although there are plans for the care manager to share the on-call role with the clinical services manager about to commence later in October 2020, the care manager is currently on-call 24/7. Care staff reported that there is always good access to advice when needed from either a manager or a registered nurse and that the care manager is always willing to lend a hand if they require assistance with a resident. They also reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence, or a shift extended and an earlier start to ensure full staff cover is maintained. A casual pool of staff assists in the process of replacing staff who have an unplanned absence. All registered nurses and senior caregivers who are team leaders have current first aid certificates, therefore at least one staff member on duty has a current first aid certificate.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by two RNs against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the

		recommended range. Good prescribing practices noted included the prescriber's electronic signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart. No residents self-administer medications at Flaxmore. Medication errors are reported to the RN and care home manager (CHM) (until a CSM is employed) and recorded on an accident/incident form. The resident's family member or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified. Standing orders are not used at Flaxmore.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service at Flaxmore is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian - 24 March 2020. Recommendations made at that time have been implemented. A food control plan audit was undertaken the week prior to audit, however documentation to verify the plan had not been received at the time of audit. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and resident's family members interviews, satisfaction surveys and resident / family meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed.
Standard 1.3.6: Service Delivery/Interventions	FA	Documentation, observations, and interviews verified the care provided to residents was consistent with their needs, goals, and the plan of care. All files reviewed had strategies documented to manage each episode of behaviours that challenge. Minimal use of antipsychotic medication was evident. The residents had lots of space to wander. The

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The unit has three wings and residents reside in the wing that is most suitable to their needs. One wing is quiet with minimal stimulation. Residents residing there do so as they are more settled in an environment with minimal noise and activity to cause mental distress. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities 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.	PA Low	The activities programme is provided by a recreation co-ordinator who is completing the diversional therapy training. Up to three days before audit there was also a qualified diversional therapist at Flaxmore, this person has now left. A 'roaming' diversional therapist (employed by the organisation) will mentor the activities coordinator to ensure the programme meets the needs of residents with dementia. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. However, the individualised activity plan does not include the resident's twenty-four-hour needs, and this requires attention. The resident's activity needs are evaluated regularly and as part of the formal six-month care plan review. A continuous improvement initiative around the use of weighted animals, in place at the last audit, has no ongoing evidence to verify ongoing assessment and evaluation of this initiative is occurring. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included movement to music, singing, origami, Men's shed, animal visits, walks, golf, volleyball, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the residents' and family members meetings. Minutes indicated input is sought from residents and resident's family and responded to. Resident and resident's family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents family members when interviewed confirmed satisfaction with the activities programme and felt it meets the resident's needs.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were consistently reviewed for infections, pain, and weight loss and progress evaluated as clinically indicated. Wound management plans were

timely manner.		evaluated each time the dressing was changed. Residents families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness on public display with an expiry date of 5 July 2021. There has been no reconstruction or modifications to the building since the last audit.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Issues related to a previously raised corrective action regarding the unpleasant odour within the facility were reviewed. Carpets have been removed, the concrete sanded and sealed and vinyl flooring laid. Deodorisers have been installed in corridors. Other than some occasional comments from visitors during day to day operations the review systems are no longer identifying this as a problem of concern. The corrective action raised at the previous audit has been closed.
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	FA	Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The infection control nurse (ICN) and care home manager review all reported infections. 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 at RN and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care

control programme.		providers. A good supply of personal protective equipment is available. Flaxmore has processes in place to manage the risks imposed by Covid-19.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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 and the role and responsibilities of a restraint coordinator. The restraint coordinator is reportedly conversant with the requirements but was unable to be interviewed during the unannounced audit as they were not on duty. A restraint meeting in August 2020 noted there were no restraints, no related corrective actions and staff education, including annual staff restraint management competencies, had been completed according to requirements. On the day of audit, there were no residents using an enabler or a restraint. Long-term staff could not recall an enabler, or a restraint ever having been used in this facility. A restraint register was sighted and confirmed no recordings have been entered. The incident involving police use of restraint was fully reviewed and because its use did not involve any Flaxmore Lifecare staff, was a one-off extreme incident and the resident was not returned to the facility, the manager and senior staff did not consider it relevant to include within the register. A Section 31 notification to the Ministry of Health was completed as noted in 1.2.4.

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)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	Compliments and complaints are being recorded and there are registers for these. The complaint register was in both hard copy and electronic format; however, the contents differed. There were also discrepancies between the quality indicator data sent to support office and the on-site number of complaints that were within either of the on-site complaint registers. Three complaints of significant issues that had been reported to staff and were discussed during the audit were not found in either version of the complaints register. There was evidence in verbal and documented reports of follow-up actions having been taken in all circumstances, but these were not all clear in the complaint registers.	Not all complaints are recorded in the complaints register and there are discrepancies between complaints in hard copy format, those recorded in electronic format and details are not consistent in clinical indicator data.	A complaints register records all complaints, including actions taken. Where a hard copy and an electronic version co-exist, the records are consistent. Complaints data used for the purpose of analysis is complete and reflects accurate reporting of complaints. 180 days

Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Moderate	Despite good records not being available for all aspects, there was evidence that incident/accident reports are being completed and followed up and verbal descriptions of investigation and follow-up to complaints were provided. There was a lack of consistency in the documented records of these processes. Infection surveillance is occurring and there are no restraints in use. According to verbal reports, health and safety is being managed but not in a formal manner. Quality indicator data is being reported to the support office, although inaccuracies in this data were observed. There was minimal evidence of the monthly quality and risk meetings or staff meetings having occurred over the past year, therefore it was not possible to confirm that key components of service delivery were linked to the quality management system.	There was insufficient information available, including a lack of quality and risk meeting minutes, to demonstrate that key components of service delivery are explicitly linked to the quality management system.	In-house recording systems demonstrate that key components of service delivery including event reporting, complaints management, infection control, health and safety and restraint minimisation are being linked to the quality management system. 90 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	Quality indicator data for incidents, complaints, falls, pressure injuries, wounds and restraint use, for example, is being collected and sent to the HLL support office on a monthly basis. The analysis of this data had not consistently been completed at the level expected. With limited evidence of quality and risk meetings having occurred and minimal records available for internal audits or for next of kin surveys, despite verbal reports they had occurred, it was not possible to confirm achievement against the quality and risk management plan is being measured. Corrective actions required were not always identified, therefore could not be actioned.	Aspects of the processes used for measuring achievement against the quality and risk management plan have not been upheld. Examples of these include internal audits, analysis of data, including for quality indicators and resident/next of kin surveys.	All measurement processes against the quality and risk management plan, such as internal audits, analysis of quality indicator data and review of information from resident/relative surveys are completed. This will enable quality improvement and corrective action to occur. 180 days

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	A range of training opportunities are provided to staff including self-directed packages, in-service presentations and access to New Zealand Qualification Authority education. Training opportunities were reduced during Covid-19 lockdown and this was exacerbated by a period of relief management. The recently appointed care manager has already demonstrated a commitment to bring the training schedule back into line with HLL's organisational requirements. However, records demonstrated that over half of the caregiver staff have not met the contractual requirements around dementia education. An annual performance appraisal system for each staff person is in place as a means to ensure safe service delivery. Fifteen staff are overdue for their annual performance appraisal. The previously raised corrective action remains open.	Over 50% of caregiving staff have not completed the dementia training as per contractual requirements (E4.5 f.). Not all staff have a current annual performance appraisal to ensure the ongoing delivery of safe and effective services for residents are monitored.	All staff complete dementia training according to contractual requirements (E4.5 f.). All staff have a current performance appraisal on file. 180 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	In five files reviewed, there was social assessment of residents' past interests, strengths, skills, family associates, lifestyle, previous lifestyle patterns and a 'map of life' is created. An activities plan is established that has a description of the activities required to meet residents' needs in relation to daily recreational activity. This is reviewed and updated on a regular basis as residents needs change; however, the plan does not reflect the residents' 24-hour activity needs.	The recreation plan for each resident at Flaxmore does not describe the residents' recreation needs during the 24-hour period.	Provide evidence the recreation plan for each resident at Flaxmore addresses the residents' 24-hour recreation needs. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.