

# Heritage Lifecare Limited - Pururi Court Rest Home and Hospital

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

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| <b>Legal entity:</b>  | Heritage Lifecare Limited  |
| <b>Premises audited:</b>  | Pururi Court Rest Home and Hospital  |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| <b>Dates of audit:</b>  | Start date: 1 October 2020 End date: 2 October 2020  |
| <b>Proposed changes to current services (if any):</b>   | None   |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 69   |

# Executive summary of the audit

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## Introduction

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

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

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         |

| <b>Indicator</b> | <b>Description</b>   | <b>Definition</b>   |
|------------------|--|---|
|                  | 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

Puriri Court Lifecare provides rest home and hospital level care for up to 72 residents. The service is operated by Heritage Lifecare Limited (HLL) and managed by a care home manager and a clinical services manager. There have been no significant changes to the service and facilities since the previous audit.

This certification 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 including a regional quality manager and a general practitioner (GP). All the interviewees spoke positively about the care provided.

There were no areas identified as requiring improvement during this audit. Two areas of continuous improvement were identified in relation to record management and service delivery.

## 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.

All standards applicable to this service fully attained with some standards exceeded.

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.

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

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

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

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

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is 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 service improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and is not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using an integrated electronic and additional hardcopy records.

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

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

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

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

## Safe and appropriate environment

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.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

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

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Five restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. There were five enablers being used. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

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

## 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         | 1                           | 49                  | 0  | 0                                    | 0  | 0                                      | 0  |
| Criteria          | 2                           | 99                  | 0  | 0                                    | 0  | 0                                      | 0  |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| Standards         | 0  | 0                            | 0                                      | 0                              | 0                                      |
| Criteria          | 0  | 0                            | 0                                      | 0                              | 0                                      |

# Attainment against the Health and Disability Services Standards

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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 1.1.1: Consumer Rights During Service Delivery<br><br>Consumers receive services in accordance with consumer rights legislation.  | FA                | Puriri Court Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, 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. Caregivers were observed calling residents by their preferred name. |
| Standard 1.1.10: Informed Consent<br><br>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA                | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent forms as needed. Advance care planning, 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.<br><br>Staff were observed to gain consent for day to day care.                                      |

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| <p><b>Standard 1.1.11: Advocacy And Support</b></p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>       | FA | <p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>   |
| <p><b>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</b></p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Residents are encouraged to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment events in the community. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Even though there were visitors' restrictions recently due to the pandemic, residents and family members interviewed stated they felt comfortable about the way it was managed and were kept well informed.</p>  |
| <p><b>Standard 1.1.13: Complaints Management</b></p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>                                 | FA | <p>The complaints 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 five complaints were received in 2019 and nine complaints have been received over the past year and that actions were taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The 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.</p> <p>There is one complaint currently being investigated by the Office of the Health and Disability Commissioner (HDC). All complaints processes have been followed through in a professional manner and all information is filed appropriately. The HLL quality and legal team have until the 08 October to respond to HDC. One complaint to the Northland District Health Board (NDHB) in 2019 was investigated and closed out effectively.</p> |
| <p><b>Standard 1.1.2: Consumer Rights During Service Delivery</b></p>   | FA | <p>Residents and family members interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in the common areas together with</p>   |

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| Consumers are informed of their rights.   |    | information on advocacy services, how to make a complaint and feedback forms.   |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.                           | FA | <p>Residents and families of Puriri Court Lifecare confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed to maintain privacy throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and in discussion with families. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings. Care plans included documentation related to the resident's 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.</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 annually.</p> |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs<br><br>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. | FA | <p>Fourteen staff and four residents at Puriri Court Lifecare at the time of audit identify as Māori. Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current organisation wide policy on Māori health plan to guide the facility on the development of their own Māori health plan. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs. Guidance on tikanga best practice is readily available.</p>  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs<br><br>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.           | FA | <p>Residents 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. A cultural assessment is also completed during the admission. The resident satisfaction survey confirmed that individual needs are being met.</p>  |

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| <p><b>Standard 1.1.7: Discrimination</b><br/>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. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Ongoing education is provided on an annual basis which is confirmed in training record. 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><b>Standard 1.1.8: Good Practice</b><br/>Consumers receive services of an appropriate standard.</p>  | CI | <p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included various quality initiatives to reduce falls rate, urinary tract infections and polypharmacy usage. Also, further to establishing part time GP link nurse role, Puriri Court rest home and hospital has expanded the scope of this role (Refer 1.1.8.1).</p> |
| <p><b>Standard 1.1.9: Communication</b><br/>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <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. This was supported 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.</p> <p>Staff know how to access interpreter services, through Northland District Health Board, if needed. Staff reported interpreter services were rarely required due to all present residents being able to speak English and/or Māori language.</p>  |
| <p><b>Standard 1.2.1: Governance</b><br/>The governing body of the organisation ensures services are planned, coordinated, and</p>  | FA | <p>The Heritage Lifecare strategic and business plans outline the organisation's direction, purpose and values, and each facility develops their own set of goals and objectives to be achieved each year. The annual plan for Puriri Court Lifecare contained detailed and time framed goals and evidence of progress being made toward these.</p>   |

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| <p>appropriate to the needs of consumers.</p>  |    | <p>A sample of monthly reports from the Care Home Manager (CHM) to their national office confirmed that the information provided is sufficiently detailed to monitor performance and includes narrative on any emerging risks and issues.</p> <p>The CHM who has been in the role for 11 weeks, is a registered nurse with a current annual practising certificate (APC) and has business qualifications and experience in the DHB and the aged care sector both in New Zealand and in Australia. Responsibilities and accountabilities are documented in that person's job description and individual employment agreement. Interview with the CHM and review of documents confirmed knowledge of the sector, regulatory and reporting requirements. The CHM has maintained and updated sector knowledge prior to taking on this role. Interview and sighted records of professional development confirmed that compliance with the requirement in the aged related resident care (ARC) contract for managers to attend at least eight hours of training annually.</p> <p>The service has a contract with the Northland District Health Board (NDHB) for rest home, respite and hospital level care.</p> <p>On the days of audit there were 69 residents on site. Nineteen of these were assessed at rest home level care, two respite and 48 residents were receiving hospital level care.</p> |
| <p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | FA | <p>When the CHM is absent the Clinical Services Manager (CSM) carries out all the required duties under delegated authority with support and back up from the quality coordinator and the regional quality manager. During absences of key clinical staff, the clinical management is overseen by one of the other senior registered nurses who is the quality coordinator/educator who knows the residents and is able to take responsibility for any clinical issues that may arise. The service also has a senior registered nurse in the role of the general practitioner liaison nurse which is unique for this service. Staff reported the current arrangements work well.</p>   |
| <p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>                         | FA | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, regular resident and relative satisfaction surveys, surveillance of infections and restraint and implementation of corrective actions.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at monthly quality management team meetings, RN and staff meetings. Staff reported their involvement in quality and risk management by the quality data on display which is discussed with them regularly as well as the results from internal audits in their work areas. A new initiative implemented by the CHM is a weekly Monday meeting for all heads of</p>  |

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|   |    | <p>department and a resident clinical review meeting held twice weekly. Minutes of these meetings are maintained and were reviewed. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey had only just occurred and results were not available on the audit days, but the number of written compliments received and the positive response from random interviews of family and residents indicated a high level of satisfaction.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The CHM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The CHM is familiar with the Health and Safety at Work Act (2015) and all requirements are implemented and embedded into the service. Staff interviewed were also fully informed in respect of their health and safety obligations and reporting systems are in place.</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. A sample of incidents forms reviewed from 2019 and 2020 showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner to prevent recurrence. Adverse event data is collated, analysed and reported monthly to HHL national office for benchmarking. The CHM and the CSM review, comment and sign off all incident reports before they are uploaded in the electronic register for collation and analysis. Significant incidents and trends are discussed with all levels of staff to promote learning and identify remedial actions.</p> <p>The CHM fully understands and described essential notification reporting requirements. Since the previous audit there have been eight section 31 notifications made to the Ministry of Health in 2019 and five this year 2020. All forms reviewed were completed accurately. There have been no coroner's inquests. One issues-based audit to follow up a complaint to the NDHB was investigated but effectively closed out.</p>   |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>  | FA | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p>   |

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| <p>accordance with good employment practice and meet the requirements of legislation.</p>   | <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The quality coordinator/educator interviewed is responsible for facilitating the education programme and maintains all records.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. Currently there are 34 health care assistants. Seventeen (17) have completed relevant training including seven level 4, four level 3 and six have completed earlier training that is NZQA eg Care of Older Persons certificated courses. Other care staff are paid at level three due to years of experience. Newly employed care staff are encouraged to enrol for 2021 in relevant training and this is currently being organised.</p> <p>All care staff have completed all relevant competencies such as restraint minimisation and safe practice, manual handling, pressure injury, fire, infection prevention and control. Senior care staff administering medicines have completed the medication competencies annually. The activities coordinators have both completed a first aid course and one has completed the diversional therapy training.</p> <p>All registered nurses have completed first aid and life support training. There are eight trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. In addition to this, three RNs are enrolled in the interRAI training for this year. Records reviewed demonstrated completion of the required mandatory and elective training and completion of annual performance appraisals.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members 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. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage at all times.</p>   |

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| <p><b>Standard 1.2.9: Consumer Information Management Systems</b></p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>            | FA | <p>The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographics, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. All resident clinical records are maintained on online patient and medication management systems. All staff has individual login/access to this information. Organisation has developed an efficient system to update all resident information onto that integrated patient management system (Refer criterion 1.2.9.10).</p> <p>Archived records are held securely on site and are readily retrievable. All hard copy documents are scanned and uploaded onto the online systems.</p> <p>Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> |
| <p><b>Standard 1.3.1: Entry To Services</b></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. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from NASC and the GP for residents accessing respite care.</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. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>  |
| <p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b></p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>                            | FA | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. 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. Family of the resident reported being kept well informed during the transfer of their relative.</p>  |
| <p><b>Standard 1.3.12: Medicine Management</b></p>   | FA | <p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p>  |

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| <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>  |    | <p>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. Regular medication audits are completed and are followed with appropriate corrective actions. There are evidences of pharmacy involvement.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's 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 is consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There are two residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors. In February 2020, a quality initiative is implemented aiming to reduce the usage of polypharmacy among the residents and it is still in the initial phase.</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> | FA | <p>The food service is provided on site by a qualified chef who is supported by experienced kitchen hands 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 in November 2019.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Whangarei District Council effective from 10 August 2020. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have completed safe food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to</p>   |

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|  |    | <p>food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>   |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | <p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with Registered Nurses (RN) and CSM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>  |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>   | FA | <p>On admission, residents are assessed to develop initial care plan. Within three weeks of admission a comprehensive assessment is completed using nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, depression scale and interRAI as a means to identify any deficits and to inform long term care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of 12 trained interRAI assessors on site.</p> <p>Files audited have evidence of wound management such as wound care plan, evaluation. Evidences of wound managements including photographs of chronic wounds is sighted. Residents and families confirmed their involvement in the assessment process.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>   | FA | <p>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 evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>   |

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| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.  | FA | Documentation, observations and interviews verified the provision of 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. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of 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<br><br>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. | FA | The activities programme is provided by a trained diversional therapist (DT) holding the national Certificate in Diversional Therapy and an activities coordinator who is currently training to be a registered DT. A wide range of activities are provided seven days a week.<br><br>A social assessment and history is 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. The resident's activity needs are evaluated as part of the formal six monthly care plan review.<br><br>The weekly activities planner sighted matches the skills, likes, dislikes and interests identified in the assessments. Individual, group activities and regular events are offered. Examples were rest home Olympics (competition among local rest homes), school children visit and external visits to vintage car show, shopping trips, day cares. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys. Residents interviewed confirmed they enjoy the programme. A quality improvement plan is initiated this year to improve the activities programme. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.  | 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.<br><br>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any   |

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|  |    | resulting changes.  |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br><br>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Puriri Court Lifecare has contracted GP who does weekly visits. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. All referrals are followed up by the GP or GP link nurse. 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 the circumstances dictate.   |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.                      | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary.<br><br>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.<br><br>There is provision and availability of protective clothing and equipment and staff were observed using this.   |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.  | FA | A current building warrant of fitness (expiry date 01 December 2020) was publicly displayed.<br><br>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and are maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe, and independence was promoted.<br><br>External areas were observed to be safe, well maintained and suitable for the resident groups and setting.<br><br>Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required. The maintenance request records reviewed confirmed that all requests are attended to in a timely way. |

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|  |    | Residents said that they were happy with the environment.   |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities<br><br>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. | FA | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility and additionally designated staff and visitor toilets. Some resident rooms have their own ensuite bathrooms with shower and toilet, some rooms have a toilet only. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Monitoring of hot water temperatures occurs regularly, and the records sighted showed no temperatures above 45 degrees centigrade.</p> <p>One bathroom was under restoration at the time of the audit and this was screened off for resident safety.</p>  |
| Standard 1.4.4: Personal Space/Bed Areas<br><br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.   | FA | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation except for three designated shared rooms. One couple share a room and the other two rooms there is only one resident in each room sighted. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is sufficient space to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.  | FA | <p>Communal areas are available for residents to engage in activities. There are two small lounge areas, one main lounge and a separate large dining room which is able to accommodate hospital level residents in wheelchairs up to the tables as needed without transfers occurring to dining room chairs. The small lounges are conveniently located to enable easy access for residents. Residents can access areas for privacy, if required. Furniture on visual inspection was in good condition and appropriate to the setting and residents' needs. There are deck areas off each end of the building near the palliative care area and an outside area which is cool in the winter months but shady in the summer. In the centre of the courtyard is a large Puriri tree with a deck area built around it for residents to sit in the shade.</p> |
| Standard 1.4.6: Cleaning And Laundry Services<br><br>Consumers are provided with safe  | FA | <p>Laundry is undertaken onsite in a laundry with two designated staff to manage this area of service delivery. One staff member has worked in this role for seventeen years and works effectively with the other team members. The clean and dirty areas are currently totally separated with plans in place to</p>  |

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| <p>and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>   |           | <p>rebuild the laundry so that both clean and dirty areas are in closer proximity to each other to improve this area of service delivery.</p> <p>Two cleaning staff with an additional staff member available to cover both the cleaning and laundry services are available. Training has been provided as confirmed in interview with cleaning/laundry staff and review of their training records. Chemicals were stored in a designated and lockable room and where needed, chemicals were being decanted into suitable and clearly labelled containers. Safety data sheets and adequate personal protective equipment and resources were sighted and available. The contracted company also has a pest control programme in place. The company involved also visits the facility regularly to check stocks and to order further supplies as needed. There is a separate lockup room for storing cleaning equipment and trollies when not in use.</p> <p>The effectiveness of cleaning and laundry processes are monitored through resident and relative feedback and the internal audit programme. All areas of the facility were observed to be clean and staff demonstrated that the daily practices occurring ensure maintenance of hygienic, reliable and regular cleaning throughout the home.</p>   |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p> | <p>FA</p> | <p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct staff in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service 04 October 2016 and trial evacuations take place six-monthly with a copy sent to the New Zealand Fire Service. The most recent trial occurred 30 June 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. The onsite fire suppression systems are checked monthly by an appropriately qualified company.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for 69 residents and the Ministry of Civil Defence and Emergency Management recommendations for the region. The emergency lighting system was being regularly tested by maintenance staff.</p> <p>The call bell system was functioning on audit day and residents and families reported staff respond promptly to call bells. The current sensor mat system is connected to the nurse call system and rings often day and night. There is a battery backup for the call bell system. The service provider is presently looking at a more effective call bell system to replace the existing nurse call system.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. An outside sensor light is installed and a security camera is in place. There have been no security incidents.</p> |

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| Standard 1.4.8: Natural Light, Ventilation, And Heating<br><br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.                      | FA | <p>All rooms provided sufficient natural light and had opening external windows. One bedroom has a ranch slider door in the palliative area which opens out onto a deck area. Heating is provided by individual electric convector heaters in residents' rooms and there were heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> <p>There is a designated smoking area for the sole resident who smokes, and the organisational smoke free workplace policy is known and adhered to by staff.</p>   |
| Standard 3.1: Infection control management<br><br>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | <p>Puriri Court Lifecare implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.</p> <p>The Quality Coordinator is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the Clinical Services Manager, who then reports it to the Regional Quality Manager. Infection control data is discussed during the staff meetings and quarterly infection control committee meetings and a copy of the minutes are available in the staff room. This infection control committee includes the Care Home manager/ Clinical Services Manager/IPC coordinator, GP link nurse, caregivers and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Due to Covid 19 pandemic (currently level 1, on the day of audit), all visitors are requested to log their visit by entering their details on a paper log or by scanning a ministry of health's bar code. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> |
| Standard 3.2: Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the                                 | FA | <p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role. He has attended relevant study days, as verified in training records sighted, and does quarterly catch ups with Infection control coordinator at the DHB. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any</p>  |

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| organisation.   |    | outbreak of an infection. There were no infections disease outbreaks reported in the facility since the last audit.  |
| Standard 3.3: Policies and procedures<br><br>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in May 2019 and include appropriate referencing.<br><br>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.  |
| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.  | FA | Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. In response to recent pandemic, staff have completed training on Covid 19 pandemic (via World Health Organisation's website), hand hygiene, isolation precautions, use of personal protective equipment and nasopharyngeal swabbing.<br><br>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the   | FA | Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  |

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| infection control programme.  |    | <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical Services Manager, IPC committee and Regional Quality Manager. Data is benchmarked internally within other aged residential facilities within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. In January 2020, a quality initiative was implemented to reduce the number of Urinary tract infections which is still progressing.</p> <p>Covid 19 pandemic preparedness document is sighted and staff interviewed are aware of this plan.</p>   |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>  | FA | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical services manager is the designated restraint coordinator who has been in this role for six years providing support and oversight for enabler and restraint management in the facility. The clinical services manager interviewed demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the day of audit five residents are using enablers voluntarily and five residents are using a restraint. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff.</p>   |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | FA | <p>HLL have terms of reference for the composition and responsibilities of the restraint approval group/committee and the practices at Puriri Court Lifecare adhere to these. Approval for the use of restraint is coordinated by the CSM who is the nominated Restraint Coordinator, the CHM, the GP, unit coordinator, resident representative and the GP link nurse. It was evident from review of restraint approval group meeting minutes, residents' files and interview with the CSM/restraint coordinator that there are clear lines of accountability, all restraints have been approved, and the overall use of restraints is being monitored and analysed. When the consent forms are signed they are scanned into the electronic system for restraint minimisation and safe practice. Interview with a family member confirmed their involvement in the approval, ongoing review and overall decision making. Safe use of restraint was clearly described in the plans of care reviewed for the five residents with a restraint intervention in place.</p> |

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| <p><b>Standard 2.2.2: Assessment</b><br/>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA | <p>Assessments for the use of restraint were documented and included all requirements of this Standard. The CSM/restraint coordinator undertakes an initial assessment with involvement and input from the resident's family/whānau/EPOA. When interviewed the restraint coordinator demonstrated good knowledge of the process and a family member confirmed their involvement and this was validated by the general practitioner confirming that they were involved and informed about the use of the restraint. During the assessment process identification of the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks were ascertained. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of all the residents who were using a restraint. A senior caregiver is the cultural advisor for the service and is called upon as necessary to meet the cultural needs of residents.</p> |
| <p><b>Standard 2.2.3: Safe Restraint Use</b><br/>Services use restraint safely</p>   | FA | <p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example, the use of sensor mats, low- low beds and 'fall out' mattresses.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>The enabler and restraint registers are maintained separately. The restraint register is kept updated and includes details about the resident, the type of restraint in use, the date of approval and commencement and review periods. The register logs the reasons for ceasing use of restraint.</p>   |
| <p><b>Standard 2.2.4: Evaluation</b><br/>Services evaluate all episodes of restraint.</p>  | FA | <p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the three monthly restraint approval committee meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. Enablers are documented in the mobility and transfer section of the long term care plan.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>   |
| <p><b>Standard 2.2.5: Restraint</b></p>  | FA | <p>Review of the three monthly restraint meeting minutes confirmed these as a comprehensive quality review of all restraint use. This meets the requirements of this Standard. Trends in restraint use is</p>  |

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| <p><b>Monitoring and Quality Review</b></p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> |  | <p>reported to the quality and staff meetings. The restraint committee consider the overall use and type of restraint in place, whether all alternatives to restraint had been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback received from other parties. Internal audits on restraint also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Policies related to restraint minimisation and safe practice are next due for review 05 December 2020.</p> |
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## **Specific results for criterion where corrective actions are required**

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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.

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

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

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

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

| Criterion with desired outcome  | Attainment Rating | Audit Evidence  | Audit Finding   |
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| Criterion 1.1.8.1<br><br>The service provides an environment that encourages good practice, which should include evidence-based practice. | CI                | Based on the positive feedbacks from residents, families and GP, Puriri Court Lifecare has expanded the role of GP link nurse. Currently it is a full time role. In addition to the previous task such as being a facility's single point of contact with GP and coordinating multidisciplinary team's inputs, this role has more responsibilities to ensure continuity and high quality of care for the residents. GP link nurse escorts residents to the external appointments which enables the specialists to get more information on resident and the feedback from specialist are followed up with GP in a timely manner. This first-hand information increased knowledge and efficiency of the nursing team which enabled better quality of care for residents. GP interviewed stated that this role is a huge success and it improved the communication with GP and efficiency of follow ups with external specialist services. | Having fully attained the criterion the service can clearly demonstrate expanding of the GP link nurse has contributed in maintaining and delivering high quality clinical care to their residents. |

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| <p>Criterion 1.2.9.10</p> <p>All records pertaining to individual consumer service delivery are integrated.</p> | <p>CI</p> | <p>In mid-2018, Puriri Court Lifecare implemented an online patient management system along with their online medication management system. All resident records are uploaded and maintained online now. Each staff has an individual login to access it. There are systems in place to access and operate these online systems during a power and/or internet outage. In case of an emergency or on call situation, implementation on integrated online patient management system and online medication management system has enabled GP to access resident data remotely. It increased the efficiency by reducing duplication and creating a single access point to all patient record. All the patient related documents/reports such as work flow sheet (handover sheet), resident or/and family contact list, allergies list can be easily accessed, updated and printed off this systems.</p> | <p>Implementation of these online systems reduced the use, handling and storage of hard copies/paper copies. Resident information can be accessed remotely for staff with right access such as GP, managers which enabled them to support the clinical team during oncall/emergency situations. Staff and GP interviews confirm that the online systems are efficient and safe.</p> |
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End of the report.