

Heritage Lifecare (BPA) Limited - Redroofs Rest 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: Redroofs Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 27 November 2020 End date: 27 November 2020

Proposed changes to current services (if any): A feasibility review is currently underway to assess the future possibility of providing hospital level care in this facility.

Total beds occupied across all premises included in the audit on the first day of the audit: 44

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

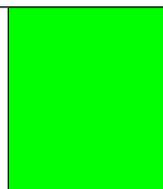
Redroofs Lifecare provides rest home level care for up to fifty residents. The service is operated by Heritage Lifecare Limited (BPA) and managed by a care home manager and a clinical services manager. Residents and families spoke positively about the care provided.

This unannounced 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, managers, staff and a general practitioner.

This audit has resulted in a continuous improvement rating in relation to the culture of implementing continuous quality improvement processes. Two areas requiring improvements were identified. These related to overdue interRAI reassessments and an unsafe aspect of the building. Improvements have been made to clinical related documentation, addressing the area requiring improvement at the previous audit.

Consumer rights

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



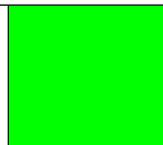
Standards applicable to this service fully attained.

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

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.

An organisational business plan and a service specific business plan were available and include a mission statement, values, goals, objectives and action plans. These are complemented by comprehensive quality and risk management plans linked to documented quality frameworks. Effective and informative monitoring of the services is provided to the governing body regularly. An experienced and suitably qualified person manages the facility and is supported by a clinical manager.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is actively 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 are current and reviewed regularly.

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

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
---	--	--

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--	--	--

There is a current building warrant of fitness on public display. There have been no modifications to the building since the last audit and fire safety and emergency equipment compliance checks were up to date. Electrical equipment is tested and tagged as required and the calibration of biomedical equipment was up to date. External areas are accessible, safe and provided shade and seating.

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.
---	--	--

Policies and procedures on restraint minimisation and safe practice are in place, as is related education. There were no enablers or restraints in use at the time of audit. Staff were aware that any use of enablers is to be voluntary and for the safety of the resident. Those interviewed 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.

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	0	14	0	1	1	0	0
Criteria	1	38	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A complaints/concerns/issues policy describes the complaint management processes, responsibilities and response timeframes and includes associated forms. All are consistent with the Right 10 of the Code of Health and Disability Services Consumers' Rights. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The care home manager is responsible for complaints management and follow up.</p> <p>The complaints register reviewed showed that thirteen complaints have been received since September 2019 when the register commenced in an electronic format. This included timeframes for each stage, the nature of each complaint, the resolution and the level of satisfaction with the outcome. Action plans showed any required follow up and improvements have been made where possible. All registered complaints have been closed, except for one, which has been passed on to the operations manager for further follow-up. The staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	<p>FA</p>	<p>Family members stated they are kept well informed about any changes to their relative's status and are advised in a timely manner about any incidents or accidents and outcomes of medical reviews. This was supported in residents' records reviewed and copies of completed incident reports. Residents also confirmed they are kept updated as necessary and can ask questions at any time. Managers and staff understood the principles of open disclosure,</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>which is supported by policies and procedures that meet the requirements of the Code.</p> <p>A policy and procedure described how to access interpreter services and managers knew where to go for local interpreter support. Although staff reported this had never been required, as English was usually residents' first language. Cue cards have been developed and are used in combination with assistance from family members for one of the current residents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>There is a Heritage Lifecare Limited (HLL) (BPA) organisational business plan, which is reviewed annually. This outlines the mission, values, scope, direction and goals of the organisation, which HLL care home managers around the country have been contributing to reviewing for 2021. A Redroofs Lifecare specific business plan, which is in the process of being reviewed in consultation with the operations manager, sits alongside the organisation's business plan. The documents described annual and longer-term objectives under each goal and included key performance indicators and associated operational plans. Due to Covid-19 and changes of managers, aspects of the plan were not able to be upheld exactly according to the action plans; however, progress updates on most areas have been documented and demonstrated clear outcomes have been achieved. A sample of monthly reports that were sent to the HLL support office were viewed and included details such as occupancy, financial performance, staffing reports, complaints, compliance, incidents/adverse events, infections, restraint use, health and safety and emerging risks. In addition, there are weekly telephone calls, some via zoom, and face to face meetings once or twice a month with the operations manager.</p> <p>The service is managed by a care home manager who is a registered nurse and holds relevant nursing and management qualifications at an advanced level. Although only in this role for approximately three months, this person has been in management roles both in New Zealand and overseas for more than 35 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The care home manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at joint provider meetings, regular contact with the portfolio manager, maintaining relationships with aged care professional bodies, and undertaking ongoing professional development in related topics.</p> <p>A clinical services manager supports the care home manager and in addition to having strong clinical qualifications this person also has extensive management experience both in New Zealand and overseas.</p> <p>The service holds contracts with the Southern District Health Board under the age-related residential care services agreement (ARRC) to provide respite and long-term rest home level residential care. Forty-four residents were receiving services under the contract at the time of audit.</p>
<p>Standard 1.2.3: Quality And Risk</p>	<p>FA</p>	<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, a regular patient</p>

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>satisfaction survey, monitoring of outcomes and clinical incidents, including infections and falls, for example, and risk management.</p> <p>Minutes were reviewed for quality and risk management meetings, staff meetings and departmental meetings. Due to Covid-19 and changes in management, the meetings had not all occurred according to the documented schedule; however, the care home manager and the clinical services manager have been working at ensuring regular review and analysis of quality indicators are back on track. Meeting minutes confirmed related information is reported and discussed, relevant corrective actions are developed and implemented to address any shortfalls, as are action plans for quality improvement initiatives. A strength of the service is the manner in which quality improvements are being implemented in response to identifying ways of improving the lives of residents as well as for action plans following adverse events. This is occurring at a level of continuous improvement, as acknowledged in criterion 1.2.3.6.</p> <p>During interviews, staff reported their involvement in quality and risk management activities through assisting with internal audits, keeping updated with organisational policies and procedures and reporting incidents and any concerns. Quality indicator data is collated and provided to the HLL support office. Monthly analyses of this data against key performance indicators are available. Resident and family satisfaction surveys were reportedly due in mid-2020 under the previous management team; however, as there were only six responses, the HLL support office reportedly informed there was insufficient data to analyse. The next date for HLL annual surveys is scheduled for June 2021.</p> <p>Policies reviewed for the specific topics of the surveillance audit included necessary aspects of the service and contractual requirements. Documents reviewed are based on best practice, referenced 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. There was no evidence of non-approved or obsolete clinical related documents in use as was raised for corrective action at the last audit.</p> <p>The care home manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Parts of the risk management processes are completed in collaboration with the HLL operations manager, parts within the quality and risk system and individual risks for residents are reviewed in consultation with the clinical services manager. Health and safety, as per the requirements of the Health and Safety at Work Act (2015), is managed by the care home manager with support from health and safety representatives, two of whom were interviewed during staff interviews. Related issues of concern and follow-up actions are documented within health and safety meetings and quality and risk management meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse,</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the six weekly quality improvement and risk management meetings. The support office undertakes an analysis of incident related data against key</p>

<p>unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>performance indicators and this is also reported and discussed at the quality meetings.</p> <p>The care home manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, or other authorities, since they commenced the role in September 2020. However, they did need to undertake a clinical review and investigate a section 31 notification sent to the Ministry of Health regarding the poor outcome following a resident's fall that occurred prior to their employment. Records of this were viewed and suggested follow-up actions were specific and continue to be followed through using continuous quality improvement processes (as mentioned in the CI in criterion 1.2.3.6).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes a formal application process, an interview, referee checks, police vetting and validation of qualifications. Copies of current practising certificates (APCs), for all registered health practitioners who support residents at Redroofs Lifecare are retained in a file. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Some records including interview records, police checks and induction/orientation records in particular were not found in staff files; however, these were for staff employed under previous managers/former facility owners.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and those who informed they had not received an orientation stated this had been rectified once the manager was informed and stated the team was supportive and always willing to assist. A checklist is a component of the orientation process, as is completion of specific competencies. A six-week and three-month interview with the care home and/or clinical service manager now occurs for all new staff.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements which are scheduled on a monthly basis according to the organisation's schedule. Records reviewed confirmed staff have had multiple opportunities to undertake a range of in-service training relevant to their role. As a number of staff were overdue for completion or review of some mandatory training topics, the managers instituted a focused system of toolbox talks and completion of self-directed learning packages to bring staff up to date and this process is now almost complete.</p> <p>The organisation has a policy that determines care staff eligibility to commence or complete a New Zealand Qualification Authority education programme, which enables the requirements of the provider's agreement with the DHB to be met. Records of where each staff person are at were viewed and included evidence that eight staff have registered for level three and others level four. The clinical services manager is the internal assessor for the programme. There is currently only one registered nurse who has and is maintaining their annual competency requirements to undertake interRAI assessments, although the clinical services manager is in the next intake and a new enrolled nurse has commenced this training. Records reviewed demonstrated the registered nurse is</p>

		undertaking required training to maintain competency. Completion of annual performance appraisals was evident in staff files reviewed and the care home manager described the internal process used to update their currency if indicated.
<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>	FA	<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 is able to adjust staffing levels to meet the changing needs of residents, although the care home manager said there has not been any indication of significantly reduced or significantly increased occupancy or acuity to suggest there might be a need to make changes. An afterhours on call roster is in place, which includes the care home manager and the clinical services manager who alternate these duties. Both managers are registered nurses, and the other registered nurse can physically go into the facility if needed and they are not able to do so. Staff have access to a registered nurse at all times and a policy has been developed to ensure staff are aware of how to do this. Additional training has been provided to staff to ensure everyone is aware of how to access additional registered nurse advice and support and under what circumstances this is to occur. Staff interviewed informed they had been well educated about these requirements and the expectations.</p> <p>Care staff reported there are now adequate staff available to complete the work allocated to them. Residents and family interviewed supported this and expressed gratitude for their input. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced by a casual staff member in any unplanned absence in all except one instance. Eight senior caregivers, the registered nurse, the enrolled nurse and both managers have a current first aid certificate (or are awaiting its issue), as do the two staff who oversee residents' outings and activities. There is a senior caregiver or a registered nurse on each shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	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> <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 as verified in staff files.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription and enters them into the system. All medications sighted were within current use by dates. Clinical pharmacist input is available on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate</p>

		<p>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 included 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 was consistently recorded on the medicine chart.</p> <p>There was one resident who self-administers pro re nata (PRN) medications at the time of audit. The GP has recommended a safe amount of medication to be provided to the resident on a daily basis. Appropriate processes were in place to ensure this is managed in a safe manner and the GP has signed a document declaring the resident as competent. The medication is stored and recorded appropriately. The resident is aware of the need for safety around medication and complies with requirements.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by two cooks and a kitchen team 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 within the last two years (7 December 2019). Recommendations made at that time have been implemented.</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 Dunedin City Council current until 31 July 2021. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have completed relevant food handling training as evidenced in staff files.</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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was 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 in a respectful manner. An initiative of a "Breakfast Club" has recently been started which involves a cooked breakfast for those residents who come to the dining room for breakfast. The residents spoke enthusiastically about it when interviewed.</p>
<p>Standard 1.3.6: Service</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>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 a good standard. Care staff confirmed that care was provided as outlined in the documentation and that they had opportunity to have input in the care planning process. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs such as pressure relieving devices.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by a qualified diversional therapist who works four days a week and an activities assistant who is undergoing diversional therapy training and works one day a week as well as her role as a caregiver.</p> <p>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. The resident's activity needs are evaluated after each activity, recording residents' engagement, and as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme stimulating and enjoyable. On the day of audit, a large group of residents was observed actively engaged in an activity. A van is available to take residents on outings several times a week. Community involvement from local schools is part of the programme as is arts and crafts, newspaper reading and entertainment.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>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 for urinary tract infections and wound management. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. Multidisciplinary meetings are held six-monthly and family have opportunity for input.</p>
<p>Standard 1.4.2:</p>	<p>PA</p>	<p>A current building warrant of fitness with an expiry date of 2 March 2021 was publicly displayed. There have been</p>

<p>Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>Moderate</p>	<p>no modifications to the building since the last audit. Fire compliance safety checks and six-monthly evacuation drills are being maintained.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. An unsafe aspect of the building was identified during the audit and has been raised for corrective action.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, and the upper and lower respiratory tract. The infection prevention coordinator's role is held by the clinical services manager (CSM) who has only been in the role three months. She reviews all reported infections, and these are documented along with treatments provided. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings 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 care home manager and the national quality manager. Data is benchmarked externally within the group.</p> <p>There have been no outbreaks since the CSM commenced the role. Policies and procedures are in place to handle an outbreak should one occur.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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. Blank forms, including for a restraint register, assessment, monitoring and review processes are included.</p> <p>The restraint coordinator, who is currently the clinical services manager, demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, there were no residents using either a restraint or an enabler. Staff interviewed could not recall a restraint ever having been used and the last person to use bed rails as an enabler chose not to use them any more around 11 months ago.</p> <p>Restraint and enabler education has been updated for all staff in October 2020. Those who did not attend were required to complete a self-directed learning package and report its completion to the clinical services manager.</p>

		During interview, staff were fully aware of the difference between a restraint and an enabler and that an enabler is used voluntarily by the person for safety reasons.
--	--	---

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>InterRAI assessments are completed by the one interRAI trained assessor. An enrolled nurse is currently undergoing interRAI training. The interRAI assessor has only been employed in the last month and has had to complete urgent reassessments for two residents with significant health changes while making steady progress in the backlog of assessments. On the day of audit there were still assessments overdue, backdating to the beginning of October 2020. The clinical services manager confirmed steps were in place to address this issue and progress has been made on the existing backlog.</p>	<p>The requirement for each stage of service provision to be provided within time frames that safely meet the resident’s needs is not being met. Eleven interRAI reassessments are outstanding dating back to the beginning of October 2020.</p>	<p>All interRAI reassessments are current and completed within the required time frames.</p> <p>180 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment</p>	PA Moderate	<p>Overall, the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the older adults in this facility. However, during</p>	<p>A half door that opens directly onto steep stairs going down to the laundry often needs to be</p>	<p>Actions in relation to a half door and steep stairs that</p>

<p>minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>		<p>a tour of the facility a half door was found to be open and residents could walk through if they chose. On investigation, this opened directly onto a steep stairway and is the route used to go to and from the facility laundry. A slide bolt is on the other side of the half door. The laundry staff person explained it had been left open as it was not possible to carry full laundry bags down, or carry armloads of laundry up, plus manage the lock, although they did try to lock it as often as they reasonably could.</p> <p>It was evident that when left open this door at the top of steep stairs presents a hazard to residents who have a degree of cognitive impairment, or who choose to go for a wander to have a look. Another factor of note is the health and safety risk posed to laundry staff carrying heavy laundry bags up and down the steep stairs. A long serving staff person reported that over the years discussions have previously occurred, but no solution had been found. These risks and hazards require corrective action as the consequence of any associated event could be serious.</p> <p>When discussed with the maintenance person and the care home manager, the maintenance person believed a short term solution was to investigate a foot operated catch and the care home manager had signs installed immediately and requested staff not fill laundry bags more than half full. Staff were informed of this requirement at handover and it was written in the staff communication book. Further discussions are to be undertaken between the care home manager and the operations manager as a priority.</p>	<p>left open; however, this poses a potential risk of harm to residents who may attempt to go down the stairs. The stairs and door also pose a health and safety hazard for laundry workers who use these facilities to transport heavy loads of laundry to and from the laundry.</p>	<p>lead to the laundry are required in order to minimise the potential environmental risks of harm for residents and to address the health and safety hazards for laundry staff.</p> <p>90 days</p>
---	--	---	---	---

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The care home manager and the clinical services manager commenced their role at a time when a number of aspects of the service had declined following the Covid-19 lockdown, the resignations of two managers and a number of staff, and reduced monitoring of clinical and quality systems. One of the responses of the two new managers was to not only re-establish the required HLL quality and risk and clinical systems, but to identify, develop and implement quality improvement opportunities. With a commitment to meeting residents’ needs and preferences, a range of quality improvement initiatives were quickly developed.</p> <p>Examples of the quality improvement initiatives included development of a residents’ council, enhancing residents’ dining experiences, increasing resident and family involvement and improving consistency of resident care. A quality action form, which included a goal, set of objectives and action plans were developed for each of these initiatives. Although it is early days, ongoing reviews, reports and evaluation processes to date confirmed development is continuing for each of these projects and continuing improvement is being demonstrated. An elected residents’ council was established, and the elected president has written an evaluation of the process to date. Their function now includes a range of roles including visiting other residents in the public hospital and welcoming new residents. Written feedback from residents through the council is requesting specific ideas, such as asking for improved</p>	<p>Over recent months, a culture of quality improvement has emerged following the development and implementation of a range of continuous quality improvement initiatives and responses to an adverse event. All have varied feedback, evaluation and</p>

		<p>bed-making. More family members are now actively involved, families meet two-monthly, are part of an email group and have their own notice board. Feedback and evaluation from these initiatives was in several different meeting minutes sighted, in a summary on the action forms and the manager's evaluation notes include the increased numbers, expressions of dissatisfaction if someone thinks they have missed something and additional support for residents for events. The enhanced dining experience has seen a dining committee, a sub-group of the residents' council, be developed. New dining tables, use of table clothes, formalising of meals, and development of a breakfast club which has seen more residents go to the dining room for special surprise breakfasts of croissants, crumpets or eggs, for example. Evaluation has not only included positive feedback in residents' meetings but a steady increase in residents getting up for breakfast and the residents adding more and more ideas to the action plans for enhancing residents' dining experiences. Meeting minutes, staff feedback and a manager's evaluation have reported positive outcomes from the project around systems in place that are improving the consistency of staffing for residents. Improved care, not having to tell staff every day what needs are, reduced staff absenteeism and better reporting back to the clinical services manager were reported, although are currently still subjective.</p> <p>This culture of continuous improvement was also evident in response to an adverse event, which occurred prior to the employment of the current managers. Following the required investigation, continuous improvements are being implemented to ensure the incidence of falls is minimised, all staff know when to contact a registered nurse when there are none on duty and that management of 'as necessary' medicines and use of neurological observations are undertaken according to documented guidelines. Ongoing evaluation of the effectiveness of these strategies is occurring.</p> <p>Each project is worthy of a continuous improvement rating in its own right; however, the auditors supported encouraging the service provider to develop on these positive early results and to ensure such good initiatives were sustainable, therefore have placed this culture of continuous improvement that has emerged under one criterion meantime.</p>	<p>review processes attached to them and the information to date is being used to improve and develop the different initiatives further. The processes in use are consistently using continuous improvement frameworks.</p>
--	--	--	---

End of the report.