

Heritage Lifecare Limited - Hodgson House

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:

Legal entity:	Heritage Lifecare Limited	
Premises audited:	Hodgson House	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 21 January 2021	End date: 22 January 2021
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	61	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Hodgson House provides rest home and hospital level care for up to 65 residents. The service is operated by Heritage Lifecare Limited (HLL) and managed by a care home and village 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 was one area identified as requiring improvement during this audit related to the timeframes for interRAI reassessments and updating of the resident care plans.

Consumer rights

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

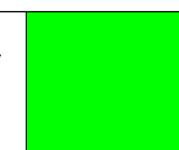
Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with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

Open communication between staff, residents and families is promoted, and 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 was no evidence of abuse, neglect or discrimination. The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints being 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.

Consumer records are integrated and securely maintained. Archived records are safely stored for easy retrieval.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--	--	--

Needs Assessment Service Coordination (NASC) team assess residents prior to entry to confirm their level of care. Assessments and care plans are completed and evaluated by the nursing staff.

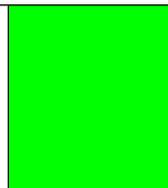
Activities plans are completed by the activity coordinators. Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whānau expressed satisfaction with the activities programme in place.

There is a medication management policy in place. Medications are monitored and reviewed as required by the general practitioner (GP) and nurse practitioner (NP). The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for.

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.

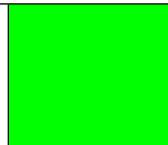
The facility meets the needs of residents and was clean and well maintained. There is a current building system status report in lieu of the building warrant of fitness for this coming year which was reviewed and is displayed. Electrical equipment is tested as required. Communal and individual spaces 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 offsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents 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 two 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	0	49	0	0	1	0	0
Criteria	0	100	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The service has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training as verified in the training records.
Standard 1.1.10: Informed Consent 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 provided relevant guidance to staff. Clinical files sampled showed that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) or residents and the general practitioner makes a clinically based decision on resuscitation authorisation if required. Staff were observed to gain consent for daily cares. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.
Standard 1.1.11: Advocacy And	FA	As part of the admission process residents and family/ whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>service were displayed and available in the facility. Family members and residents interviewed were aware of the advocacy service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family/whānau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family/whānau and friends. Family/whānau interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints and associated forms meet the requirements of Right 10 of the Code. Information on the complaint/compliments process is provided to residents and families/ whānau on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that four complaints were 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 care home and village manager (CH&VM) is responsible for complaints management and follow up. Both hard copy and electronic records are maintained. All staff interviewed confirmed a sound understanding of the complaint/compliment process and what actions are required.</p> <p>There are no complaints being investigated by the Office of the Health and Disability Commissioner (HDC) or other external agencies.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Māori and English. Family/ whānau and residents interviewed were aware of consumers' rights and confirmed that information was provided to them during the admission process.</p> <p>The information pack outlines the services provided. Resident agreements signed either by the resident or by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with residents assessed as rest home and hospital level of care, able to move freely into the surrounding areas and in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The clinical services manager (CSM) reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. The GP reiterated that there was no evidence of any abuse or neglect reported. Family/ whānau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. The Māori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. It also recognises the importance of whānau. Assessments and care plans document any cultural/spiritual needs. Special consideration of cultural needs is provided in the event of death as outlined in the policy. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. There were three residents and five staff members who identify as Māori on the audit days.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whānau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they are encouraged to be involved in the development of resident lifestyle plans. Residents' personal preferences and special needs were included in the resident care plans sampled.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p>	FA	<p>Family/whānau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and this was confirmed by the residents. The induction process for staff</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		includes education related to professional boundaries, expected behaviours and the code of conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The CSM stated that there have been no reported nor alleged episodes of abuse, neglect or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through ongoing professional development of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. The GP reported that conferences are organised where various medical topics are discussed with staff members drawn from organisation they manage. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Shift handovers are completed between registered nurses and then huddles are conducted with care givers. Staff are provided with toolbox talks on different nursing and safety issues by the unit coordinator and CSM respectively.</p> <p>Policies and procedures are linked to evidence-based practice.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Family/whānau members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards is encouraged. Those with visual impairment are supported by the Blind Low Foundation New Zealand that provides braille books.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The Heritage Lifecare Limited 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 business plan for Hodgson House is currently being reviewed for 2021 and contained detailed and time framed goals and evidence of progress being made toward these. The CH&VM stated that the regional quality and regional operations managers sign off the business plan when completed.</p> <p>A sample of monthly reports from the CH&VM and the clinical services manager (CSM) to their national support office confirmed that the information provided is sufficiently detailed to monitor performance and includes narrative on any emerging risks and issues.</p> <p>The CSM was appointed the acting CSM 9 April 2020 and moved into the permanent position on the 11</p>

		<p>July 2020. The CSM is a registered nurse with a current annual practising certificate (APC) who has vast nursing and aged care sector experience. Responsibilities and accountabilities are documented in that person's job description and individual employment agreement. Interview with the CH&VM and review of documents confirmed knowledge of the sector, regulatory and reporting requirements. The CH&VM 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 (ARRC) contract for managers to attend at least eight hours of training annually is met.</p> <p>The service has a contract with the Bay of Plenty District Health Board (BOPDHB) for rest home, respite and hospital level care. Since the last audit the service has an agreement for three palliative care beds.</p> <p>On the days of audit there were 61 residents on site. Twenty-four of these were assessed at rest home level care exclusive of one respite rest home level care, two palliative care and 34 residents were receiving hospital level care (including one accident corporation commission (ACC) resident).</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the CH&VM is absent the CSM carries out all the required duties under delegated authority with support and back up from the regional quality manager and the regional operations manager. During absences of key clinical staff, the clinical management is overseen by one of the other senior registered nurses who is the unit coordinator who knows the residents and is able to take responsibility for any clinical issues that may arise. The general practitioner and the nurse practitioner are also available for clinical advice if needed. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation 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. Clinical and non-clinical staff are informed with posters of up and coming meetings. Staff reported their involvement in quality and risk management and the minutes of meetings are displayed and are accessible to read and be informed. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed July annually. The most recent survey July 2020 results were reviewed, and these were benchmarked with against other services in the organisation. Two areas of improvement identified from the survey outcome report lead to corrective</p>

		<p>actions reports being developed one for environment and one for meal service delivery which have since been improved and feedback from family and residents has been positive. The few 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 CH&VM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The CH&VM 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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed from 2020 - 2021 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 support office for benchmarking. The CH&VM 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 CH&VM fully understands and described essential notification reporting requirements. Since the previous audit there have been seven section 31 notifications made to the Ministry of Health (MoH) - HealthCERT. All forms reviewed were completed accurately. Latest information received from the MoH has been updated in the relevant policy to guide staff. One notification was also reported to HealthCERT and the appropriate agency in relation to a gastric outbreak infection in March 2020.</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</p>	<p>FA</p>	<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. An APC register is maintained electronically. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation</p>

<p>the requirements of legislation.</p>		<p>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 CSM and unit coordinator interviewed are responsible for facilitating the education programme and the administrator maintains all records. An education assessor has not been appointed yet for this role.</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 38 care givers employed including casual staff. Twenty-eight (28) have completed relevant training and level 4, six (6) level 3, two (2) level 2 and two newly employed staff are yet to be enrolled for 2021 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 three activities coordinators have all completed a first aid course and one has completed the diversional therapy training. The maintenance manager has also completed first aid training.</p> <p>All registered nurses have completed first aid and life support training. There are five trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. In addition to this, two registered nurses are enrolled for 10 March 2021 to complete the relevant training. 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. The general practitioner and/or the nurse practitioner are on call 24 hours a day seven days a week.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	<p>FA</p>	<p>A resident register is maintained of all current and past residents. Resident individual information is kept in paper and electronic format. The resident's name, date of birth and National Health Index (NHI) number</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>are used as the unique identifier on all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with the GP and allied health service provider notes. Written records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. These include, NASC assessment, discharge summary and other required documents. Assessments and entry screening processes are documented and clearly communicated to the residents, family/whānau where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements were conducted within the required time frames and are signed on entry. Family/whānau and residents interviewed confirmed that they received sufficient information regarding the services to be provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital and the organisation's transfer discharge form to another service. Residents and their family/whānau are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There is a documented policy on the management of the medication system. All medication entries sampled confirmed that they are reviewed as required and discontinued medications are indicated by the GP. Allergies are documented, identification photos are current and three-monthly reviews are completed. The RNs were observed administering medication correctly in their respective wings. Medications were stored in a safe and secure way in locked trolleys and in respective treatment rooms. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from hospital or any external appointments. The service uses pharmacy pre-packed packs that are checked by the RNs on delivery. The controlled drug register was current and correct. Weekly, monthly and six-monthly stock takes are conducted. Monitoring of medicine fridge and room temperatures are conducted regularly and deviations from normal were reported and attended to promptly.</p>

		Residents who are self-administering medication are assessed as competent to do so and medication was stored in a secure way. There is a policy and procedure for self-administration of medication. An annual medication competency is completed for all staff administering medications and medication training records were sighted. The medicines management system complies with legislation, protocols and guidelines.
<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>There is an approved food plan for the service. The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Residents are provided with alternative meals when needed and are encouraged to complete a meal request form. Diets are modified as required and the cooks confirmed awareness on dietary needs of the residents. There is a six-weekly rotating winter and summer menu in place. Meal services are prepared on site and served in the allocated dining rooms. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required.</p> <p>The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night. The family members and residents interviewed acknowledged satisfaction with the food service.</p> <p>The kitchen was registered under the food control plan and the registration expires 27 November 2021. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates were on all containers. Records of food temperature monitoring, fridges and freezers temperatures were maintained. Thermometer calibrations are completed three-monthly. Regular cleaning is conducted.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The CSM reported that all residents who are declined entry are noted. Reasons for refusal are explained. When a resident is declined entry, family/whānau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider. All outcome of entries are recorded on the resident information form.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences</p>	FA	<p>Residents have their level of care identified through a needs assessment by the assessment agency. Initial nursing assessments are completed on admission, while residents' lifestyle plans and interRAI are completed within three weeks according to policy. Subsequent interRAI assessments were not developed along with activity and resident lifestyle plan and activity plan refer (1.3.3.3). Assessments and care plans</p>

<p>are gathered and recorded in a timely manner.</p>		<p>were detailed and included input from the family/whānau, residents and other health team members as appropriate. Additional assessments are completed according to the need; this included pain, behavioural, falls risk, nutritional requirements, continence, skin and pressure assessments. The nursing staff utilised standardised risk assessment tools on admission. In interviews conducted, family/whānau and residents expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The assessment findings in consultation with the resident and/or family/whānau, inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans are used for short-term needs. Family/whānau and residents interviewed confirmed they are involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professional's involvement in the care of the resident such as the mental health services for older people, district nurses, physiotherapist, podiatrist, dietitian and GP.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Interventions in the service delivery plans were relevant to address the assessed needs and desired goals/outcomes. All significant changes were reported in a timely manner and prescribed orders carried out. The CSM reported that the GP and NPs medical input was sought in a timely manner, that medical orders were followed, and care is person centred. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The planned activities are meaningful to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Residents' files sampled reflect their preferred activities and were evaluated, however activity care plans were not in sync with interRAI assessments (Refer 1.3.3.3). The activities coordinator is assisted by an assistant activities' coordinator, volunteers and students on placements. The activities coordinator develops a monthly activity planner which covers activities for the rest home and hospital level of care residents. These were posted on the notice boards to remind residents of upcoming activities. Residents' activities information was completed in consultation with the family during the admission process.</p> <p>The residents were observed to be participating in a variety of activities on the day of the audit. There are planned activities and community connections that are suitable for the residents. There are regular outings for all residents. Residents and family/whānau interviewed reported overall satisfaction with the level and</p>

		variety of activities provided.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' lifestyle plans, interRAI assessments and activity plans were evaluated at least six monthly and updated when there were any changes (Refer 1.3.3.3). Resident care is documented on each shift by care staff in the progress notes. The registered nurses completed progress notes daily and as necessary. All noted changes by the care staff were reported to the registered nurses in a timely manner. Relatives and staff were involved in the care planning process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans were developed when needed and signed and closed out when acute problems have resolved. Monitoring of residents' change of care needs is conducted weekly via zoom meetings or as needed by the regional quality manager and RNs. Evidence of completed change of care needs forms were sighted. The CSM reported that this assisted in re-assessments of residents in a timely manner.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents and family/whānau are supported to access or seek referral to other health and/or disability service providers where required. If the need for other non-urgent services are indicated or requested, the GP, NP and the nursing team sends a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses, NP and GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to the public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 26 January 2021) was publicly displayed. A building systems status report provided states that a report has been issued in lieu of a building warrant of fitness (Form 12). A building warrant of fitness was unable to be supplied and displayed for the next current year due to Covid 19 Alert level restrictions preventing one or more scheduled inspections and/or maintenance procedures of the compliance schedule from being carried out. All specified systems in the building are currently performing to the performance standards stated in the buildings and compliance schedule.</p> <p>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.</p> <p>External areas were observed to be safe, well maintained and suitable for the resident groups and setting.</p> <p>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.</p> <p>Residents said that they were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility and additionally designated staff and visitor toilets. Rest home resident rooms' have their own designated toilet and hand basin. Two additional communal toilets and two showers are available. There are two hospital wings in one area called Wisteria. All rooms have shared ensuites with two hand-basins. Four other hospital wings in Magnolia have shared ensuites, with only one standard room that does not have an ensuite bathroom. There are four extra toilets and separate showers available if needed. Toilets are available for staff and visitors to the facility.</p> <p>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>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All 65 bedrooms provide single accommodation. There are no shared rooms. Rooms are personalised with furnishings, photos and other personal items displayed. There is a homely atmosphere</p>

adequate personal space/bed areas appropriate to the consumer group and setting.		<p>and the service is well maintained on a daily basis.</p> <p>There is sufficient space to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. A special area is designated for motor scooters to be stored when not in use. Facilities are provided for charging batteries and changing plugs</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. There are four lounge areas, one extra-large lounge and a separate sunroom. There are three large dining rooms and one small dining area. The designated library provides a separate small quiet lounge 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 two large courtyards and several small courtyard areas with seating and shade provided for residents to enjoy.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a laundry with two designated staff to manage this area of service delivery seven days a week. One staff member has worked in this role for 23 years and works effectively with the other team members. The laundry is large in size with planned and implemented clean and dirty areas.</p> <p>Four cleaning staff with three care staff as additional staff members are available to cover both the cleaning and laundry services if and when required. Training has been provided as confirmed in interview with cleaning/laundry staff and review of their training records. Bulk chemicals were stored in a designated and lockable room and when needed, chemicals were being decanted safely 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 sluice 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>
Standard 1.4.7: Essential, Emergency, And Security	FA	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

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>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 31 January 2006 and trial evacuations take place six-monthly with a copy sent to the New Zealand Fire Service. The most recent trial occurred 15 October 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 65 residents and the Ministry of Civil Defence and Council Emergency Management recommendations for the region. The requirements for the BOPDHB agreement are also in place and quarterly key stakeholder group meetings are attended at the DHB by the CH&VM. Minutes of meetings were reviewed. The emergency lighting system was being regularly tested by maintenance staff. Foot lights are installed throughout the building and wall lights operate from the nurses' station. All emergency supplies in all service areas are checked on a regular basis as per the internal audit schedule. Diagram photographs with step by step processes are available in the event that the gas and/or water mains at street level have to be turned off in an emergency were available and accessible.</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>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All 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 and offices. Areas were warm and well ventilated throughout the audit and residents and family/whānau confirmed the facilities are maintained at a comfortable temperature.</p> <p>The organisational smoke free workplace policy is known and adhered to by staff.</p>
<p>Standard 3.1: Infection control management</p>	<p>FA</p>	<p>The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input</p>

<p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>from external specialists. The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted.</p> <p>The CSM is the designated infection prevention and control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results are reported monthly to the regional quality manager and to the monthly staff and management meetings.</p> <p>The infection control manual provides guidance for staff on how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents.</p> <p>There is information that covers aspects of infection control for family/whānau and if they are unwell; it is recommended that they do not visit the service. During higher risk times of community infections and winter months, notices are placed at the door to remind people not to visit if they are unwell. There is sanitising hand gel at the entrance and throughout the service. Hand washing and sanitiser dispensers are readily available around the facility.</p> <p>There was an infection outbreak reported and this was managed according to policy and all relevant notifications were completed. Evidence of this was sighted in reports and documents reviewed. Information on the management of the novel coronavirus was readily available for staff and visitors. Toolbox talks on Covid-19 and pandemic plans were in place.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control coordinator (ICC) has appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control.</p> <p>Additional support and information are accessed from the regional quality manager, the infection control team at the DHB and the GP or NP as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by the organisation with advice from external specialists. Policies were last reviewed in 2019 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and</p>

<p>and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>gloves. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff education on infection prevention and control is conducted by the ICC, regional quality manager and other specialist consultants. The infection control coordinator attended infection prevention and control training conducted by an external consultant to keep their knowledge current. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included the GP, NP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Data is benchmarked against other sister facilities and this process has provided assurance that infection rates in the facility are below average for the sector. Staff interviewed reported that they were informed of infection rates at monthly staff meetings and through compiled reports. The GP or NP are informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p>
<p>Standard 2.1.1: Restraint minimisation 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. The clinical services manager is the designated restraint coordinator who has been in this role for five 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 two 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</p>

		the restraint approval group minutes, files reviewed, and from interviews with staff.
<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	Heritage Lifecare Limited have terms of reference for the composition and responsibilities of the restraint approval group/committee and the practices at Hodgson House adhere to these. Approval for the use of restraint is coordinated by the CSM who is the nominated restraint coordinator, the CH&FM, the GP/nurse practitioner, unit coordinator and resident representative. 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 then 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>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	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 and/or unit coordinator demonstrated good knowledge of the process and a family member confirmed their involvement and this was validated by the general practitioner/nurse 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.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>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/whānau 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>Standard 2.2.4: Evaluation</p> <p>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. Family/whānau 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. Evaluations are discussed and information is documented at the restraint meetings three monthly. Minutes of the restraint meetings were reviewed.</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>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</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 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 currently being reviewed at support office.</p>

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>	<p>PA</p> <p>Moderate</p>	<p>InterRAI assessments and resident lifestyle plans were completed within three weeks of admission by the nursing team. Subsequent six monthly interRAI assessments were not in line with resident lifestyle plans and activity plans. Resident lifestyle plans were developed in consultation with residents, family/whānau, and care and activities staff. This was confirmed by family/whānau in interview conducted. Evidence of this was sighted in the residents' files sampled.</p>	<p>Resident lifestyle plans and activity plans were not in sync with six-monthly interRAI evaluations.</p>	<p>Provide evidence that interRAI assessments are in sync with resident lifestyle plans and activity plans evaluations.</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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.