

Heritage Lifecare Limited - Colwyn 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: Colwyn House

Services audited: Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

Dates of audit: Start date: 27 January 2021 End date: 28 January 2021

Proposed changes to current services (if any): Only two of the four additional beds approved for use by the District Health Board, as per a Ministry of Health reconfiguration letter, have been remodelled. Reconstruction of the rooms for the remaining two has not yet commenced.

Total beds occupied across all premises included in the audit on the first day of the audit: 68



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

Heritage Lifecare Limited - Colwyn House (also known as Colwyn House Lifecare) provides rest home dementia care and specialised hospital dementia care. Up to 71 residents may be cared for in this facility. The service is operated by Heritage Lifecare Limited and managed by a care home manager with support from a clinical services manager and a unit coordinator. Two new rooms have been opened up since the last audit and reconstruction of another two is about to commence. Family/whānau members interviewed are very satisfied with the services being provided and spoke of the caring nature of the staff.

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/whānau, management, staff, contracted allied health providers and a general practitioner.

This audit has resulted in two areas of continuous improvement, one being in relation to communication processes and the other infection control. Six areas for improvements were identified and these relate to internal audits, staff appraisals and four aspects of the restraint standard.

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.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents when they are admitted to Heritage Lifecare Limited-Colwyn House. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services at Heritage Lifecare Limited-Colwyn House are provided in a manner that respects the choices, personal privacy, independence, individual needs and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The clinical team advise family/whānau members about how to make a complaint at the time of admission and additional information is available at the front entrance. 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.		Some standards applicable to this service partially attained and of low risk.
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An organisational business plan includes the scope, goals, values and mission statement of Heritage Lifecare Limited. There is a facility-based business plan that reflects goals and action plans specific to Colwyn House. Quality and risk plans guide implementation of the quality and risk management system. Regular reports on the effectiveness of the services and the levels of achievement of the goals are provided to the governing body. An experienced and suitably qualified person manages the facility.

Internal audits are completed, adverse events are investigated, satisfaction surveys reviewed and infection surveillance and clinical indicators are collected and collated. This quality improvement data is analysed, trends are identified and corrective actions are generally implemented when indicated. Staff are involved in implementation of the quality system and feedback is sought from families. Actual and potential risks, including health and safety risks, are identified and mitigated. The organisation's policies and procedures are current and reviewed regularly to describe services and monitoring processes.

Human resource processes around the appointment, orientation and management of staff are based on current accepted practice. A systematic approach to identify and deliver ongoing training supports safe service delivery. Staffing levels and skill mixes are meeting the needs of residents with replacements found for absences.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. Specialist approval is required prior to entry. When a vacancy occurs, relevant information is provided to the potential resident/family/whānau to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

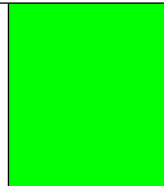
The planned activity programme is overseen by a diversional therapist and four activity coordinators. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings, and additional community van is available for outings if needed.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

Waste and hazardous substances are managed according to organisational requirements and sub-contracts. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and internal audits enable the laundry processes to be evaluated for effectiveness.

A current building warrant of fitness is on public display and appropriate equipment and services checks are being completed. Electrical equipment is tested as required, bio-medical equipment is calibrated and hot water temperatures are safe. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire evacuation drills. Adequate emergency equipment and supplies are available. A range of security systems are in place and 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation implements policies and procedures that support the minimisation of restraint. At the time of audit, six restraints are in use. Documentation to enable comprehensive assessments, approvals, monitoring systems and regular reviews is accessible to staff. Staff reported their understanding of restraint processes, especially the need to monitor use of a restraint.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control officer, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from the Hawkes Bay District Health Board.

The programme is reviewed annually.

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, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	5	1	0	0
Criteria	2	93	0	5	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Heritage Lifecare Limited-Colwyn House (Colwyn House) has policies and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information.</p> <p>Advance care planning, establishing, and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>All residents' files reviewed had EPOAs in place that had been activated as a result of the resident having mental incapacity.</p>

consent.		Staff were observed to gain consent for day-to-day care on an ongoing basis.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, resident's family/whānau/EPOAs are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the advocacy service were also displayed in the facility. Family/whānau members spoken with were aware of the advocacy service, how to access this and their right to have support persons. A representative from the advocacy service runs the family/whānau meeting every quarter. Any concerns that arise out of that meeting are addressed with the CHM if requested. No meeting minutes are kept for that meeting. Staff were aware of how to access the advocacy service.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	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' families/whānau and friends. Family/whānau members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints and compliments policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and family/whānau on admission. Family/whānau interviewed knew how to do so and informed that raising concerns and receiving feedback has dramatically improved with the change of manager. Copies of compliment and complaint forms, information about advocacy services and a box for compliments, suggestions and complaints was viewed in the reception area. The complaints register reviewed showed that 16 complaints have been received over the past year, eight of which have been categorised as relating to some form of communication, seven about quality and risk/attention to detail and one around safety concerns. Copies of documentation related to each complaint and the register demonstrated that actions had been taken, through to an agreed resolution and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The care home manager is primarily responsible for complaints management and follow up, although the clinical services manager and/or the unit coordinator will become involved if they relate to clinical issues. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. One complaint has been received from an external source (Health and Disability Commission - HDC) over the

		<p>past year and this was closed within one month. The service provider developed their own action plan and some actions of a quality improvement nature are still being worked through internally. Documentation from two other HDC complaints, both from 2019, was viewed and relevant responses have been made. One of these complaints remains open with responses provided as requested. Attention was paid to the following issues raised from these complaints during the audit and included: complaints management, assessments related especially to weight loss, wound care and falls, service delivery for general care, wound and falls management and weight loss management, communication, good practice (staff training), medicine management and the nutritional needs of residents. Specific reviews of these areas during the audit confirmed that the standard and good practices are now being met and maintained and there were no corrective actions identified in these areas.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family/whānau members of residents when interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</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>Residents and resident's family/whānau members confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room. Security cameras operate in common areas of the facility and signage alerts residents, visitors and staff to them being operational.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</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>There were six residents and six staff who identified as Māori at the time of audit. Interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. The clinical service at Colwyn House is led by a clinical manager (CM) who is passionate in ensuring the needs of all Māori and other cultures are met by Colwyn House.</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>Residents and/or their family/whānau members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family/whānau members of resident when interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed a high degree of satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a code of conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care</p>

<p>Practice</p> <p>Consumers receive services of an appropriate standard.</p>		<p>specialist, services for older people, and older persons mental health services and ongoing education of staff. Eighty five percent of care giving staff are in training programmes, with the remaining 15% waiting to enrol in the upcoming programme. Twenty three percent of staff have level four training and 20% have level three. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional learning opportunities through on-line learning hubs such as Ko-Awatea.</p> <p>Observations of the units on the day, were of three units that were very settled. No evidence of challenging behaviours was sighted. The residents acknowledged and were familiar with the care home manager (CHM) and the CM, who both knew all residents by name.</p> <p>A review of clinical processes identified that most days at Colwyn House at least an hour was spent by the CM, RN or senior care giver ringing around attempting to cover last minute shift shortages. This had the potential to compromise the delivery of resident care and clinical leadership due to key staff being kept off the floor. An initiative to rectify this is recognised as one of continuous improvement.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family/whānau members of residents stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family/whānau input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the local court or the Hawkes Bay District Health Board (HBDHB). Several residents spoke Te Reo, as did a number of staff. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</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</p>	<p>FA</p>	<p>A business plan for 2020 was sighted. Six group overarching goals cover finances, residents and staff satisfaction, the provision of quality clinical care, health and safety and promotion of Heritage Lifecare Limited. An overview of goals for 2020 covers finances, residents, quality/clinical and health and safety, staffing and property and maintenance. Business requirements and measures of success are against each. Colwyn House's own business plan was viewed and demonstrated how Colwyn's own goals and action plans had been integrated into the organisation's template. The template for 2021 has been released and work has commenced on the 2021 business plan for both the organisation and Colwyn House. The care home manager provides quarterly reports on these goals to the support office alongside comprehensive monthly reports and copies of</p>

<p>of consumers.</p>		<p>these documents were viewed.</p> <p>A Heritage Lifecare Limited document titled 'the Heritage Way' includes the organisation's vision of being a significant provider of aged care services throughout New Zealand especially in the area of residential care for older people. Its overall mission is: 'The continued pursuit of excellence in care through monitoring, auditing, actioning and evaluation of service whilst respecting and valuing our residents, families and staff'. Its five underlying values are integrity, respect and value, commitment, effectiveness, and efficiency, which are promoted around the facility.</p> <p>The care home manager has been in the role for one year. A curriculum vitae was viewed, which alongside discussion about previous roles in management, leadership and compliance, confirmed the manager holds relevant qualifications. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Although not previously from the aged care sector, the care home manager has developed a good knowledge of this sector, regulatory and reporting requirements. The care home manager is well supported by a Heritage Lifecare Limited operations manager and is maintaining currency through attendance at in-service sessions when applicable, DHB portfolio manager forums, the Heritage Lifecare Limited regional conference for managers and consultation with other local managers in the aged care sector.</p> <p>The service holds contracts with the local District Health Board under the Aged Related Residential Care (ARRC) agreement covering dementia rest home level care and hospital specialised services for psychogeriatric care. A respite and day care contract has been signed and although respite services are no longer provided, day care services are still available. The provider has a contract for long term support – chronic health conditions; however, there is not currently any person funded under this contract. None of the managers interviewed were aware of why the certificate states hospital services - medical services; hospital services - geriatric services (excl. psychogeriatric), as these services are not provided.</p> <p>There are 71 beds currently available within this facility, of which 68 were occupied the night before the audit and there was an admission on day one of the audit. Twenty-six residents were receiving services under the dementia- rest home contract in the Matai wing, 22 in Kowhai wing where psycho-geriatric services are provided and 20 in the quieter Pohutukawa wing where psychogeriatric services are also provided. A Ministry of Health request to check a reconfiguration of four new beds was followed through and it was found that only two of these have been developed to date. Both rooms are in use, one of which has an ensuite attached, and meet the requirements for the dementia services being provided in them.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation</p>	<p>FA</p>	<p>The clinical services manager carries out all the required duties under delegated authority when the care home manager is absent. If the absence is for an extended period, a temporary manager from Heritage Lifecare Limited may be available, otherwise the operations manager, or one of the team from support office will assist or advise when required.</p>

<p>of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>During absences of the clinical services manager, the unit coordinator is able to take responsibility for any clinical issues that may arise. Additional support is available from a range of sources including a gerontology nurse specialist, a local nurse practitioner, the GP, other registered nurses within the team at Colwyn House and registered nurses from other Heritage Lifecare facilities. Staff informed they are very satisfied with the level of support currently available across all shifts.</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>	<p>PA Low</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. Key elements of the quality program at the organisational level are the policies and procedures, the internal audit schedule and associated audit tools, care home health checks, education plans, quality alerts, clinical advisory group, benchmarking and key performance indicators, satisfaction surveys and external audits. At the care home level, the key elements are annual quality goals, internal audits, corrective action plans, quality action forms, incident reporting system, satisfaction surveys, education plans, quality meetings and complaints and compliments.</p> <p>A template for recording quality meeting minutes covers each of the above-mentioned aspects and minutes from the monthly quality and risk meetings at Colwyn House are being entered into these accordingly. Meeting minutes confirmed that identified key clinical indicators are also being analysed, reported against and presented to the registered nurse meetings and to the quality team each month. Reports from household staff, laundry, maintenance and the kitchen are presented at each quality meeting. A risk and corrective action plan developed by the local District Health Board following an earlier complaint and follow-up visit has since been closed, December 2020.</p> <p>A meeting schedule for various staffing groups has been developed and these meetings are enabling information from quality team meetings to filter through the various departments of the facility. Meeting minutes are available for people who were unable to attend.</p> <p>Staff reported their involvement in quality and risk management activities through attending meetings, reporting areas of concerns to the relevant manager, completing the different forms and records they are asked for and attending training. A workshop in a staff roadshow facilitated by support office, focused on staff values in the workplace. The care home manager informed that staff are reminded of these at times of stress to try and keep staff morale high and maintain high levels of care.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls in the review of the organisation's systems; however, a corrective action has been raised as not all of these are being followed up and resolved. A satisfaction survey was sent to residents' relatives mid-2020 with most feedback being positive. Some suggestions in the comments section have been extracted for action and include ensuring there is adequate handover between staff when shifts change, increasing the number of activities available, concern over shrunken woollens and ramps to the outside where there is a ridge. The care home manager has a good</p>

		<p>understanding of quality improvement projects and examples of these were provided during the audit. In addition to the two identified in the reports as examples of continuous improvement, planning is underway to address the suggestion of ramps at sliding doors and the one for additional activities.</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. These are based on best practice and although there are ongoing reviews of the organisation's policy documents a number fall due for review in March 2021. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>A risk management system describes the meaning of risk, includes a risk matrix/likelihood table and a consequence table. Organisational and workplace risks are measured using severity assessment codes (SAC) ratings of one through to four using the headings workforce, systems and processes, financial and environmental. The processes for the identification, monitoring, review and reporting of organisational risks and development of mitigation strategies are led by staff in the support office. All risk reporting comes through quality and risk management reporting systems.</p> <p>A comprehensive health and safety system is implemented. Three staff have undertaken Worksafe health and safety training and are familiar with the Health and Safety at Work Act (2015). Requirements are being implemented and the care home manager advised additional on-line training is being planned for three key staff. An overarching hazard register is available and is accompanied by one that is specific to Colwyn House. Updates are being maintained.</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 either in hard copy or electronically. 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 through monthly quality and risk meetings and then departmental meetings.</p> <p>The care home manager described essential notification reporting requirements, including for pressure injuries and one of these was completed in consultation with the operations manager on the day of audit. Documentation confirming other instances when notifications of significant events had been made to the Ministry of Health was sighted. Support office staff are involved when a notification is filed. There have been no other types of notifications to authorities required.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>PA Low</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes an application process, initial interview, referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. This includes records of annual practising certificates for all health professionals involved with residents from Colwyn House.</p> <p>Staff orientation includes all necessary components relevant to the role. During interviews, staff stated orientation had previously been a bit and miss and are pleased the process has been reviewed and additional time is offered when considered necessary or when requested by the new staff person. Staff records reviewed show documentation of completed orientation, even in historical records from the previous provider.</p> <p>A comprehensive education programme includes mandatory training requirements. Continuing education is planned on an annual basis and the calendar includes mandatory training requirements. Spreadsheets confirm that all required registered nurse competencies are up to date. Records reviewed informed there are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. A planned approach has been implemented to ensure caregivers commence or make progress along the path of a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. More than 80% of staff have either completed or are enrolled in the required dementia care education. Efforts have been made to update staff who have not completed this requirement; however a manager described how these have been compromised by some staff lacking the necessary literacy skills and by Covid-19, as there have been less places available on training courses amidst higher than usual demands. There are sufficient casual staff to relieve those needing to complete training requirements and the presence of an internal assessor on-site is facilitating the process. Bureau staff are used as a last resort, but the care home manager informed this was an option to ensure registered nurse competencies are maintained.</p> <p>Annual performance appraisals are a strategy used to ensure safe and effective services are being provided to consumers. Not all staff have undergone a performance appraisal within the last year, as per good practice and as required by the organisation's policies. This has been raised for corrective action.</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>A staffing levels and skill mix policy and procedure and an accompanying rostering policy describe processes for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Rostering records and staff and management interviews confirmed that these policies are being implemented.</p> <p>The care home manager noted there has not been any need for significant changes in in staff numbers on the roster as when a person has needed additional attention then they have received this as not all beds were occupied. An afterhours on call roster is in place, with staff having access to both clinical and non-clinical expertise for advice and decision-making. Care staff reported they have access to additional advice and support when required and informed there were adequate staff available to complete the work allocated to them. Most family/whānau members interviewed supported this with two wondering if there were time when</p>

		<p>more would be helpful, especially for activities. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence, or alterations to the length of shifts made to maintain cover. All registered nurses, activities staff, the van driver, a cook, a cleaner and more than half of the caregivers have a current first aid certificate, therefore there is always at least one staff member on duty who has a current first aid certificate. There is 24/7 registered nurse cover in the hospital specialised services psychogeriatric care units.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records are all electronic with the name and designation of the person making the entry identifiable.</p> <p>Hard copy archived records are held securely on site and are readily retrievable using a cataloguing system. All records since two years ago are electronic.</p> <p>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>Electronic medication records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter Colwyn House when their required level of care has been assessed and confirmed as being required by the local Needs Assessment and Service Coordination (NASC) Service and authorised by a medical specialist. Prospective residents and/or their families / whānau are encouraged to visit the facility prior to admission and meet with the CHM and the CM. Residents' family/whānau or EPOAs are also provided with written information about the service and the admission process.</p> <p>Family/whānau members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the HBDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services and the resident's family/whānau. At the time of transition between services, appropriate information, including medication records and the care plan is provided</p>

planned and coordinated transition, exit, discharge, or transfer from services.		for the ongoing management of the resident. All referrals are documented in the progress notes.
<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 member 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. Interviews with the RNs verified any ambiguity around prescriptions would be followed up with the GP or CM. A previous concern around the prescribing of nutritional supplements and dosage, has been addressed by the GPs. Clear guidelines around the preparation of nutritional supplements are posted in all three medication rooms.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There are no residents who self-administer medications at Colwyn House.</p> <p>Medication errors are reported to the RN and CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Colwyn House.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian on 15

<p>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>January 2021. Recommendations made at that time have been implemented.</p> <p>An up-to-date food control plan is in place at Colwyn House, issued 9 December 2020 by Hastings District Council, and due to expire 9 December 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</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>The kitchen in Colwyn is off the secure rest home dining room. Residents can observe the cook preparing the meals, with the cooking odours wafting through the unit. Food is transported in heated bains-marie to the other two units. Both other units have kitchenettes. Food items are accessible to the residents anytime night and day. The main kitchen has food supplies that are accessible to staff if needed. Residents who wander and at times do not want to sit for meals, have their meals on the move. One resident with a walker and a tray on the front, wheels the meal around while eating. An interview with one family/whānau member, identified a concern around the size of the meal perhaps not being big enough. Records of weight verified the resident's weight was stable, however care staff will now serve up bigger meals. Second helpings are always offered, and the cook verified there was no shortage of food supplies.</p> <p>Evidence of resident satisfaction with meals is verified by interviews with resident's family/whānau members, satisfaction surveys and family/whānau meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</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</p>	<p>FA</p>	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family/whānau are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family/whānau. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

managed by the organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission residents of Colwyn House are assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, behaviours, and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require. Reassessment is sighted frequently regarding residents' behaviour management plans, medication and nutritional plans.</p> <p>Interviews, documentation, and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels. This was evidenced in notes reviewed in the tracer of the rest home resident.</p> <p>All residents have current interRAI assessments completed by seven of eight trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed. Residents' files include behaviour management plans, triggers and interventions for behaviour. Comprehensive planning is sighted regarding managing the triggers that are precursors to residents' behaviours.</p> <p>Care plans evidenced service integration with progress notes, activities note, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families/ whānau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	FA	<p>Documentation, observations, and interviews verified the provision of care provided to residents at Colwyn was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. Interventions are</p>

<p>desired outcomes.</p>		<p>individualised and diverse to meet the range of needs the residents at Colwyn have. The manner of the nurse's response is consistent with that identified by the resident's previous lifestyle experiences. Interventions are often at a time that meets the residents need, not the routine of a facility. Staff are flexible in adapting to the regime the resident chooses that day.</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 at Colwyn is provided by a trained diversional therapist and four activities co-ordinators (one who is part time). The programme operates seven days a week, until 6.00pm in the secure hospital units, and five days a week until 4.30pm in the rest home unit.</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 a 24-hour approach to an activity programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal care plan review every six months.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include exercise sessions, van outings, entertainment, travel memories, quizzes, music and sing-a-longs, happy hour - bosses shout, games, gardening, baking, poetry and reminiscing sessions. Every fortnight there is a men's group that is run by male staff. All the units come together and do fix it type jobs, fixing a toaster or pulling things apart and talking male chat. A women's group meets fortnightly and do beautician sessions, baking, sewing etc. The activities programme is discussed at the monthly family/whānau meetings. Minutes indicate family/whānau members input is sought and responded to. The family/whānau meetings are run by the CHM and CM though every third meeting is run by the advocate from the advocacy service. This enables family's free time to discuss freely any concerns. Resident and family/whānau satisfaction surveys demonstrate. Interviews with eight family/whānau members confirmed they find the programme meets the resident's needs.</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 CM and RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care, for example; medication review for behavioural concerns, nutritional review for weight loss, medication reviews following an increase in falls, increased sleepiness. Short-term care plans are consistently reviewed for infections, pain and weight loss and progress evaluated as clinically indicated. Wound management plans were evaluated each time the dressing was changed, Behaviour management plans are reviewed after any outburst or challenging event.</p>

		Family/whānau members interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<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 are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or CM sends a referral to seek specialist input. Interview with the GP verifies access to afterhours medical services. The CM verifies the community team from Mental Health Services for older people (MHSOP), are responsive to requests for assistance. This was further acknowledged at interview with a visiting occupational therapist from MHSOP. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the CM or the GP. The resident's family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Documented processes for the management of waste, and infectious and hazardous substances guide staff actions. Contractors supply skips for general waste, green waste and recyclable cardboard, which are removed twice a week. Recyclables of paper, glass and plastics are placed in bins collected by the local council each week. A separate company removes medical waste and sharps as requested.</p> <p>Bulk chemicals are stored in a dedicated chemical storage area in one wing with appropriate signage displayed. Material safety data sheets were viewed where chemicals are stored. Staff interviewed knew what to do should any chemical spill/event occur.</p> <p>Protective clothing and equipment are available and staff described when and why they use it. Staff were also observed using these items.</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</p>	FA	<p>A current building warrant of fitness with an expiry date of 28 February 2021 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The maintenance person uses a series of primarily electronic systems, which demonstrate any necessary repairs are undertaken in a timely manner and the tasks on organisation's annual maintenance schedule are completed within the required timeframes. Testing and tagging of electrical equipment and calibration of bio medical equipment including resident weighing scales, thermometers and sphygmomanometers for example are current as confirmed in documentation reviewed, interviews with</p>

purpose.		<p>maintenance personnel and observation of the environment. Records sighted confirmed that hot water temperatures are checked from a sample of different outlets each month and temperatures are safe, or action is taken. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas were safely maintained and appropriate to the resident groups and setting. There were a number of external courtyards and gardens off each wing, which were tidy and provided areas of interest for residents to move around in.</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>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. For the 20 rooms in the Pohutukawa wing, there are three ensuites with a toilet and a shower, three shared toilets and showers and one single toilet for residents' use. In the 26 bed Matai wing, there is an ensuite in the new room, two single toilets and four shared bathrooms with a toilet and a shower in each. The 25 bed Kowhai wing has two shared toilets and three shared bathrooms, which have a toilet and a shower in each.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories including shower chairs and a hydraulic bathing trolley for example are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms provide single accommodation. Each room is sufficiently large enough for residents and staff to move around them easily and safely. Rooms are personalised at different levels depending on the occupant. Decorative furnishings and personal items are displayed. Personal identifications on doors were evident to assist residents to identify their room, and in one wing doorframes and bedroom doors were painted different colours to assist this.</p> <p>There is sufficient room for the use and storage of mobility aids and wheelchairs as required. Staff and family/whānau members reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>A range of communal areas are available for residents to engage in activities. There is a dining and lounge area in each of the three wings. All are spacious and enable easy access for residents and staff. Residents can move around freely and access various smaller areas for privacy, such as a small, quieter television lounge in</p>

<p>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>		<p>Matai. Additional furniture is appropriate to the setting and residents' needs.</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>	<p>FA</p>	<p>Laundry is undertaken in a purpose-built on-site laundry. The key laundry staff person demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Instructions for laundry processes are available. According to survey results, family/whānau are satisfied with laundry processes overall.</p> <p>Staff involved in cleaning duties receive appropriate training in both cleaning techniques and use of chemicals. Cleaning products currently in use were labelled and stored in a box on cleaners' trolleys, which are stored in locked cupboards when not in use. An external company is contracted to manage the supply of cleaning chemicals and provides staff with access to on-line training on chemical safety. One of the longer-term cleaning staff assists new staff to upskill.</p> <p>Cleaning and laundry processes are monitored through the service provider's internal audit programme. The laundry and cleaning staff reported they see the audits as ways of improving their practices.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 17 March 2015. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 1 July 2020 and the next due February 2021. The orientation programme includes fire, emergency and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including three to four day's supply of food at all times, extra blankets, plastic bins with civil defence supplies checked against a list six monthly and gas BBQ's were sighted. These are sufficient for the requirements for full occupancy of 71 beds and staff on duty and meet the Ministry of Civil Defence and Emergency Management recommendations for the region. Water storage tanks are located in the attic areas of the buildings. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. The care home manager reported monitoring of call bells and there was no evidence of family/whānau members reporting any delays in call bell responses. There are</p>

		<p>plans to update the call bell system to a more modern electronic system.</p> <p>Appropriate security arrangements are in place. Double locked gates are on both sides of the property and all windows have security latches in situ. Swipe cards are in use for most doors and where there are door codes these are only known by staff. Doors and windows are locked at a predetermined time and a security check is completed by staff at the evening to night staff shift change. Security cameras have been installed and appropriate signage is on display.</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>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light from external windows, which are split horizontally and open forward to prevent anyone trying to get out, while at the same time enabling ventilation. A small number of bedroom doors open onto enclosed outside garden or small patio areas.</p> <p>A heat pump air conditioning system has been installed in the newest wing and each bedroom has its own vent which can be independently adjusted. Heat pumps are in the lounges and dining areas of each wing and in the two new bedrooms. Gas is used for heating the bedrooms in the two older wings, although this ducted and vented heating system is nearing the end of its life and there are plans in place to replace this with air conditioning units.</p> <p>At the time of audit, windows and some doors were open and there was good ventilation occurring as the wings without air conditioning were very warm. The manager was observed to alter the temperature of one area when a resident complained they were too warm.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the CM. The infection control programme and manual are reviewed annually.</p> <p>The RN with input from the CM is the designated infection control nurse officer, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CM, and tabled at the quality/risk meeting, staff and RN meetings. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisations national quality manager is informed of any IPC concern.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>

		An initiative to manage the potential spread of Covid-19 within Colwyn House, is recognised as an area of continuous improvement.
<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 control officer (ICO) has appropriate skills, knowledge, and qualifications for the role. The ICO has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from the organisations quality and risk team is available if additional support/information is required. The officer has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The CM confirmed the availability of resources to support the programme and any 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 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>	FA	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year 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 gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICO. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was</p>

infection control to all service providers, support staff, and consumers.		<p>maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections scabies outbreak.</p> <p>Education with residents and their families is generally on a one-to-one basis and has included reminders about handwashing and increasing fluids during hot weather.</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>	FA	<p>Surveillance of infections at Colwyn House is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is recorded in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The CM reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality, RN and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>There have been no norovirus outbreaks at Colwyn House in the past year. There was a scabies outbreak in October 2020 and a recent respiratory infection outbreak, whereby residents were tested for Covid-19 and the facility went into lockdown. The HBDHB and public health were involved. Evidence is sighted of monitoring, and the cleaning regime introduced to manage the risk. Swabs identified rhinovirus, with possible community connection.</p> <p>A good supply of personal protective equipment is available. Colwyn House has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and was aware of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, six residents were using restraints, one of whom was using two types. All were bed rails when the person is in bed or chair briefs.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was reported by management and staff during interviews.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, made up of the registered nurses, are responsible for the approval of the use of restraints and the restraint processes. Although monthly registered nurse meeting minutes in relation to restraint were scant, it was evident from separate interviews with the restraint coordinator, two other registered nurses and the clinical services manager that conversations are extensive. Documentation in the residents' files confirmed all restraints in use had also been approved for use in a dementia service by the attending GP.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint is part of the plan of care.</p>
<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>	<p>PA Moderate</p>	<p>The organisation requires that an assessment of a resident's use of a restraint is completed and a record is retained within the resident's personal file. There is a lack of consistency in the level of restraint assessment documentation, including family/whānau/EPOA and the assessments not meeting the requirements of the standard. Registered nurse meetings operate as a replacement for a restraint approval group and restraint is a topic on the agenda for each meeting; however, this is not documented at the level expected. These issues have resulted in a corrective action being raised.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Low</p>	<p>Efforts are being made to reduce the use of restraints with one restraint having been discontinued as recently as earlier in the month of the audit. Although no records could support it (refer 2.2.2.1), the restraint coordinator described how alternatives to restraints are discussed at registered nurse meetings, and with family/whānau.</p> <p>Documentation related to restraint use and monitoring processes do not meet the requirements of the standard and these factors have been raised for corrective action. Staff interviewed confirmed all restraint processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint, the date it was first approved, the method of restraint, date of last review, date of next review and funding. There is sufficient information to provide an auditable record of restraint use.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively</p>

		supporting people with challenging behaviours. Those interviewed understood that the use of restraint is to be minimised.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	PA Low	<p>Residents' files of people who use a restraint showed that the individual use of restraints is reviewed during care plan and interRAI reassessments at six-monthly intervals. The restraint coordinator and the clinical services manager and two registered nurses stated these occur and are discussed at monthly registered nurse meetings, although there was limited evidence to confirm this.</p> <p>As the documentation of evaluations of restraint use do not cover all requirements of the Standard, a corrective action has been raised.</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>	PA Low	<p>Individual use of restraint use is reported to the quality and risk meetings and the numbers and type of restraint use are reported through the monthly reports to the operations manager. Minutes of registered nurse meetings reviewed lacked sufficient detail to confirm any analysis or evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and family/whānau. A corrective action has been raised to rectify these issues.</p> <p>A six-monthly internal audit is carried out and reported to the quality and risk meetings. There have not been any reported changes to policies, guidelines, education and processes; although one person has had their restraint discontinued and one other was reported to have reduced frequency of implementation.</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 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	<p>The organisation’s quality and risk management plan describes a range of processes that measure achievement against the quality and risk related goals. One of these measures is the internal audit system, which monitors many aspects of service delivery, the environment and human resources for example. Although a monthly schedule of the audits over a twelve-month timeframe is available, not all of these have been completed as required. Corrective actions have been identified in examples of completed internal audits; however, quality and risk meeting minutes demonstrated that there was a lack of consistency in the follow-up of these corrective actions. There was a disconnect between the transfer of information from the record of the audit to the quality and</p>	<p>Internal audits are occurring as a measure of achievement against the quality plan; however, these are not being completed according to the organisation’s current schedule. Also, corrective action processes for any shortfalls in internal audits are not always</p>	<p>Internal audits are undertaken according to the developed schedule. Associated corrective actions are completed and reported through the quality and risk management system to demonstrate achievement.</p> <p>180 days</p>

		risk reports and in some instances they were transferred but not followed up the following month, which meant they then became lost to the system.	being completed in a timely manner due to breakdowns in the transfers of information.	
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	Annual staff performance appraisals are a method of ensuring safe and effective services are provided to residents. A sample of ten staff human resources files were reviewed during the audit. For 80% of these, there was no record of the staff persons having completed a performance appraisal in the past year. One manager confirmed they were aware that not all of the non-clinical staff had had an appraisal update during the past year. The master list of due dates for performance appraisals of clinical staff was provided and one of the management team informed they understood these had been completed. A corrective action has been raised as the dates of these appraisals had not been entered into the master record, copies of the appraisals were not evident in staff files and it was confirmed that those of non-clinical staff were not all up to date,	Not all staff performance appraisals have been completed over the past 12 months as required by human resource policies.	<p>Each staff person has completed a performance appraisal with a manager within the previous twelve months.</p> <p>180 days</p>
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p>	PA Moderate	Assessments for the use of restraint were documented within residents' files when applicable, although these were difficult to find as some were in hard copy and some in their electronic record. There was also	Assessments for clients using restraints have not covered the requirements of	Assessments for clients using a restraint cover (a) to (h) of the standard and are fully

<p>(a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.</p>		<p>evidence of confusion between documentation related to restraint approval processes and that of restraint assessment processes. Information in the documented assessments for the use of restraint were limited and did not clearly reflect the requirements in (a) to (h) of the standard.</p> <p>A registered nurse undertakes the initial assessment. The general practitioner is involved in the final decision on the safety of the use of the restraint, although this record was not found in two residents' files reviewed. There is some evidence of input from the resident's family/whānau/EPOA, although this was not consistently recorded clearly. Restraint approval group/registered nurse meeting minutes did not describe when a new assessment had been completed. As the assessment processes is integral to ongoing use of restraints and so many aspects of this lacked consistency, a moderate risk has been allocated.</p>	<p>the standard and approval and assessment processes not well documented.</p>	<p>documented within the resident's files and within registered nurse/restraint approval meetings minutes.</p> <p>90 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered,</p>	<p>PA Low</p>	<p>Residents' restraint related documentation lacks detail regarding the use of restraint, duration, outcome and details listed in (a) to (g) in criterion 2.2.3.4. When restraints are in use, frequent monitoring is expected to occur to ensure the resident remains safe. However, records of restraint monitoring lack the necessary details and the times of restraint use are not consistent with those that are available in assessment records.</p>	<p>There is a lack of clarity in the residents' documentation about the detail regarding the use of restraint, duration, outcome and details listed in (a) to (g) in the standard. Records of</p>	<p>Restraint use and monitoring records are documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to requirements as</p>

<p>provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.</p>			<p>restraint monitoring lack the necessary details and the times of restraint use are not consistent with those that are recorded.</p>	<p>listed in (a) to (g) of this standard. 90 days</p>
<p>Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers.</p>	<p>PA Low</p>	<p>Reports provided confirmed restraints are being reviewed as review dates were documented in the residents' files and in the restraint register, all of which had been completed within the past six months. There was minimal evidence of collaboration with family/whānau/EPOA and the residents' GPs and some files stated a review had occurred; however, there was not always a signature to verify this despite it being many months previously. Documentation of the reviews of restraint use were scant and did not demonstrate there had been a full evaluation process of its use. There was insufficient evidence that options to eliminate use had been discussed, of the impact and outcomes of the restraint, whether the policy and procedures were followed and if the documentation had been completed as required.</p>	<p>Dates of the last review of restraint use are recorded, however, records are sparse and do not adequately inform whether required processes are followed and associated risks are mitigated.</p>	<p>The use of each restraint is evaluated in collaboration with the resident's family/whānau/EPOA and their GP according to (a) to (k) of the standard. 180 days</p>

<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	<p>PA Low</p>	<p>Restraint use is reported through the quality and risk system and to governance. Registered nurse meetings are used as a platform for review of all restraint use. Although meeting minutes include restraint as a topic discussed, the information recorded does not cover the details as listed in (a) to (h) and do not demonstrate regular comprehensive reviews are undertaken.</p>	<p>Restraint monitoring and quality review processes are not currently meeting the requirements of the standard.</p>	<p>Comprehensive reviews of all restraint use are undertaken regularly and cover the requirements of (a) to (h) in this standard.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>A review of clinical processes identified that most days at Colwyn House at least an hour is spent by the CM, RN or senior care giver ringing around attempting to cover last minute shift shortages. This had the potential to compromise the delivery of resident care and clinical leadership due to key personnel being kept off the floor. An investigation was undertaken by management to find options available that would enable Colwyn staff to fill rostered vacancies quickly. An electronic telecommunications system was identified and implemented as a trial. Four staff groups have been set up comprised of RNs, caregivers, casual caregivers, and support staff. When someone is unable to come to work, the person contacts the CHM, CM or RN, who sends an email that delivers as a text message to the appropriate group, advising them of the need.</p> <p>Evidence is sighted of a response within two minutes, and 95% of requests addressed with the shift being covered. Service delivery time on the floor has improved, due to key staff time being required to be on the phone. Staff members are also available for work more quickly.</p>	<p>An initiative to reduce the time spent on the phone by the CHM, CM and RN covering last minute shift changes has resulted in less time being spent doing this, enabling more time to be spent on the floor delivering and overseeing</p>

			resident care.
<p>Criterion 3.1.9</p> <p>Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.</p>	CI	<p>During the Covid-19 outbreak it was recognised that resident safety could be compromised if there was an outbreak. The configuration of Colwyn House, the complexities of the residents and their associated disorders meant Colwyn House would be unable to contain residents in a safe manner. Management suggested a solution to contain a small section of the facility by sectioning off a part of the unit using portable walls that would not impact on fire safety regulations. An upholsterer was contacted with the idea. Vinyl and plastic walls were constructed, which had extendable steel poles, fitting from floor to ceiling. The walls had a wall and zipper in them, which allowed access. The walls were put in place when staff were requested to accept two residents from a facility that had had an outbreak of Covid-19 but were deemed clear. Colwyn House was required to isolate those residents for two weeks. The two residents were accommodated in an area with three bedrooms and a bathroom. The third bedroom was used as a lounge. This area was sectioned off. Staff worked 12 hour shifts in this area, entering and leaving the unit by an external door. The walls were successful in managing the isolation requirements of residents. The HBDHB infection control team visited and saw the idea and have contacted the manufacturer to make their own set. The walls can be put up and taken down if required to be used for any outbreak.</p>	<p>Colwyn House implemented a process to be able to contain the residents in a secure unit in a secure and safe manner, while keeping other residents safe, during Covid-19 and subsequent outbreaks.</p>

End of the report.