Heritage Lifecare (BPA) Limited - Broadview Rest Home & Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Heritage Lifecare (BPA) Limited
Premises audited:	Broadview Rest Home & Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 24 June 2021 End date: 25 June 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 79

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

Broadview Rest Home and Hospital provides rest home and hospital level of care for up to 85 residents. The service is operated by Heritage Lifecare Limited and is managed by a care home and village manager who is supported by a clinical services manager responsible for the clinical management of residents.

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

The audit resulted in two areas identified as requiring improvement in the care plan process and the activities programme hours of implementation.

Consumer rights

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

Open communication between staff, residents, and families is promoted. There is access to interpreting services if required and most documents are in a language that is spoken and understood by the residents and relatives. Staff provides residents and families with the information they need to make informed choices and give consent.

The care home manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Business and quality and risk plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services is provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The business plan is documented with clear objectives for the service to achieve. Quality and risk management system includes collection and analysis of quality improvement data, any trends are identified and/or any issues raised are acted upon. Quality improvement is promoted. Feedback is sought from staff, residents and families. Adverse events are documented and followed up appropriately. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery as needed.

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

Continuum of service delivery

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

Broadview Rest Home and Hospital provides services in a manner that promotes continuity in service delivery and a team approach to care delivery. All processes for assessment, planning, provision, evaluation, review, and exit are provided and completed by suitably qualified personnel. InterRAI assessments and individualised care plans are completed. When there are changes to the resident's needs, a short-term care plan is developed and integrated into a long-term care plan, as needed. Residents in the mental health and psychogeriatric wings are assessed for risk and where required a risk management plan is developed and monitored. Early warning signs and triggers and relapse prevention strategies are included.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activities are conducted in the mental health, psychogeriatric, dementia, hospital, and rest home wings. Residents and family/whānau expressed satisfaction with the activities programme in place.

There was a safe electronic medicine management system. The medicine administration system was observed at the time of audit. Staff involved in medication administration are assessed as competent. The general practitioner (GP) or nurse practitioner (NP) completes three monthly reviews or more frequently as needed.

Food services meet the preferences of residents and special diets are catered for. There is a food control plan in place. Nutritional snacks are available for residents 24 hours a day.

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.

All building and plant complies with legislation and a current building warrant of fitness was publicly displayed.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support minimisation of restraint. Three enablers were in use at the time of the audit and six restraints. Use of enablers is voluntary for the safety of residents in response to individual requests. The restraint team meet six monthly to review the use of both enablers and restraints. Policy identified that assessment, approval and monitoring processes meet the restraint standard requirements. Staff interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

There is a documented surveillance programme with is appropriate to the size and scope of the service.

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	16	0	2	0	0	0
Criteria	0	49	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaint forms are available on-line and at the entrance to the hospital and to the rest home. Complaints and compliments can also be placed in a locked complaints box at reception. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. The complaints register reviewed electronically showed that 10 complaints had been received over the past year and that actions were taken through to an agreed resolution, were documented and completed within the required timeframes. All have been closed out effectively. Any quality improvements have been made where possible. The care home and village manager and the support office head of clinical services are responsible for complaints management and follow up. There have been two health and disability commissioner complaints and both were closed out with the last being on 26 May 2021 (closures are authorised only by support office). One coroner's case was open at the last audit and this was closed out 29 November 2019.
Standard 1.1.9: Communication Service providers	FA	Family members stated they were kept well informed about any changes to their relative's health status, were normally advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews This was supported in residents' records sampled and in interviews conducted. In interviews conducted, residents and families expressed positive feedback on staff attitude, prompt response to residents' care

communicate effectively with consumers and provide an environment conducive to effective communication.		needs, and staff knowledge. Staff understood the principles of open disclosure, which is supported by policies and procedures. Personal, health, and medical information is collected to facilitate the effective care of residents. There were no residents who required the services of an interpreter; however, the staff knew how to access interpreter services if required. Regular handovers at the beginning of each shift provide continuity of care. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic, quality and business plans, which are reviewed annually, outline the purpose, values, cope direction and goals of the organisation and the personalised goals for this facility are also documented for 2021 and 2022. Six goals are set and are reviewed regularly for progress and achievement. A sample of monthly and quarterly reports to governance at support office includes the monitoring performance outcomes, quality data results, staffing, complaints, quality improvements made and any emerging risks and issues. The service is managed by an experienced nurse who has completed comprehensive and psychopaedic training. The care home and village manager (CH&VN) was previously in the clinical services manager (CSM) role and is supported by a clinical services manager. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements reviewed. All of the management team confirmed their knowledge of the aged care sector and maintain currency through regular ongoing clinical and management education related to their individual roles. This was confirmed in education documentation sighted. The service holds contracts with the DHB for rest home, hospital, respite, dementia level care, long term support chronic health conditions (LTSCHC), primary options for acute care (POAC), residents on accident compensation corporation (ACC), specialist psychogeriatric and mental health. There were 79 residents on the day of audit 14 rest home and 35 hospital level care residents including three (3) LTSCHC under 65years, nil ACC, POAC and/or respite level care, seven (7) mental health and eight (8) psychogeriatric residents receiving care.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and accidents, complaints, audit activities, monitoring of outcomes, clinical incidents including infections, falls, skin tears, wounds, challenging behaviours and pressure injuries. A regular resident/family satisfaction survey has been completed and the results were provided 21 June 2021. A good response rate was recorded with 60% received at support office. Positive feedback was encouraging as stated by the CH&VM. In addition to this annual survey being completed an external provider survey was completed by ‘Best Practice Australia’ called ‘At a Glance’ in 2019. The general manager of operations and the regional operations manager presented this back to the organisation for quality improvements across all services through the ‘Culture and Engagement Workshops’ held 1 October 2020.

system that reflects continuous quality improvement principles.		Residents and families interviewed expressed positive views on the staff and services provided. The CH&VM stated that any concerns raised by residents or family/whānau are followed up using the corrective action process. Meeting minutes confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly management quality and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Policies reviewed cover all necessary aspects of the service delivery and contractual requirements. The document control system to manage the policies and procedures from support office is currently being addressed as discussed with the CH&VM to ensure they are reviewed in a timely manner. Obsolete documents are removed from the system when updated. The CH&VM described the processes for the identification, monitoring and reporting of any risks and development of mitigation strategies. The management team are fully informed and familiar with the Health and Safety at Work Act (2015) and the requirements have been implemented. The service has a health and safety team who actively maintain and review all known and newly identified hazards and risks. The maintenance co-ordinator was not available for interview. The hazard registers are maintained and are current at all times for each area of service delivery.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse and near miss events on the electronic system in place and this generates an incident form. Each resident has their own incident register. The CSM is alerted if an incident occurs on any shift. Incidents sampled were investigated, action plans developed and actions followed up in a timely manner. Adverse event data is collated, analysed and reported in the monthly reports by the clinical manager and reports are sent to the CH&VM and to the CSM for review. A monthly report is collated over the entire site, for example challenging behaviour episodes, medication errors, falls, fractures, restraint, skin tears and inclusive of any wounds and/or pressure injuries. Any unwitnessed falls followed up evidenced a post falls assessment being completed and neurological observations being performed as required. The CH&VM and the CSM described essential notification reporting requirements, including pressure injuries. They advised that there have been thirty seven (37) section 31 notices completed and sent to HealthCERT. The high number is reflective of the nature of providing two specialist mental health services. There have been no police investigations, coroner's inquests, issues based audits and any other notifications such as infection outbreaks, during this time. One coroner's case open at the previous audit was closed out 29 November 2019.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resource management policies, procedures and processes are based on good employment practice and required legislation. The recruitment process includes, police vetting checks from previous employers, referee checks and validation of qualifications and annual practising certificates (APCs) for all health professionals employed and/or contracted to the service. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The service is actively recruiting registered nurses and this is ongoing. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. An orientation checklist applies and is signed off by the registered nurses (RNs) as achieved. Any issues are discussed at a six week review for all new staff. Staff appraisals are undertaken annually and records are maintained in the individual staff records reviewed. The Heritage Lifecare education plan for 2021 was available to review. Continuing education is planned on an annual basis, including all mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. There are 63 healthcare assistants and 10 have completed level 4, 15 level 3, 24 level 2 and 14 are either enrolled and/or have not yet enrolled into the training. Two of four activities staff have completed level 4 diversional therapy training. Five of 19 registered nurses (including two management) are interRAI competent to complete the required interRAI assessments on admission and six monthly thereafter. Two RNs are enrolled currently. Registered nurses can attend elective study days and training as well as being involved in the Heritage Lifecare training for all staff.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery 24 hours a day seven days a week (24/7), (refer to 1.3.7.3). Observations of six weeks of staff rosters identifies that the facility adjusts staffing levels to meet the changing needs of residents. Staff are replaced in any unplanned absence. An afterhours on call roster is in place with staff interviewed reporting that good advice is available when needed. The afterhours is covered by the CH&VM, CSM and a senior registered nurse. The service does not use bureau staff. The CH&VM has the ability to increase staffing as needed ensuring appropriate skill mix applies. Care staff reported there were adequate staff available and team work is promoted. Family and residents interviewed supported this. All registered nurses have completed first aid training and a list of staff is maintained with these additional skills. Non-clinical staff are rostered to cover all other aspects of service delivery including kitchen staff, laundry, cleaning, maintenance and ground staff.
Standard 1.3.10: Transition, Exit, Discharge, Or	FA	Exit, discharge, or transfer is managed in a planned and coordinated manner, with an escort/family member as appropriate. There is a documented process in place and open communication between all services, the resident, and the family. At the time of transition, appropriate information is provided to the person/facility responsible for the

Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		ongoing management of the resident. The service uses the DHB transfer forms to facilitate the transfer of residents to and from acute care services. All referrals are recorded in the progress notes. All required documents such as resuscitation status, recent progress notes, care plan, identified risks, early warning signs, relapse prevention plans, behavioural monitoring, and medication charts are included in the discharge or transfer pack. In the mental health wing residents were assessed for risks and processes were put in place to manage all risks identified. Residents can be referred or discharged for further management to the acute mental health unit at the local DHB.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There is a documented policy on the management of the medication system. All medication entries sampled confirmed that they were reviewed as required. Allergies were documented, identification photos were current and three-monthly reviews were completed. The registered nurse (RN) was observed administering medication correctly. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from the hospital, for new admission or when there are any medication changes. The service uses pharmacy pre-packed packs that are checked by the RNs on delivery and documented in an electronic medication management system. Controlled drug registers were current and correct. Weekly stock takes were completed by the RNs while the pharmacy was completing six-monthly controlled drug audits. All medications were stored appropriately and in a secure way. Medication audits were conducted, and corrective actions have been acted on. Monitoring of medication fridge and the room temperatures was maintained. Outcomes of pro re nata (PRN) were documented. There were no residents self-administering medication and there is a policy and procedure for self-administration of medication if required. Self- administration of medicines is encouraged for YPD residents who wish to do so if appropriate. An annual medication competency is completed for all staff administering medications and medication training records were sighted. The medicines management system complies with legislation, protocols, and guidelines.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this	FA	The food service is run by four cooks who are assisted by kitchen assistants. The kitchen service complies with current food safety legislation and guidelines. There is an approved food control plan for the service which expires 22 July 2021. Meal services are prepared on-site and served in the respective dining areas. The menu was reviewed by the registered dietitian on 18 May 2021. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents' weight was monitored regularly, and supplements were provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required. Food is delivered to the respective wings in the hot scan boxes and microwaves are used to warm up food in all wings if

service is a component of service delivery.		required. The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers are maintained. The residents and family/whānau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The outcome findings from interRAI assessments and input from residents and/or family/whānau inform care plan development and assists in identifying the required support to meet residents' goals and desired outcomes (Refer 1.3.3.1). The care plans sampled were resident-focused and individualised. Short-term care plans sampled contained a problem list, goal, intervention, evaluation, and completion date, and were appropriate for the identified problem. Behaviour management plans were completed for psychogeriatric, mental health residents as well those assessed as requiring dementia level of care. Early warning signs and relapse prevention plans were documented. Triggers were identified with detailed interventions to manage the behaviours of concern. Cultural needs were identified in the care plans in the care plans sampled. YPD and mental health residents had person-centred care plans in place and community involvement is encouraged. Family and residents confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services, gerontology nurses, physiotherapists, occupational therapists, district nurses, dietitians, diversional therapists (DTs), NP, and GP.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders were carried out. Wound, behaviour assessments, including care plans, were being completed and evidence of this was sighted in files sampled. The clinical services manager (CSM) reported that the GP or NPs medical input was sought within an appropriate time-frame, that medical orders were followed, and care was person-centred. This was confirmed by the NP during the interview conducted. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources was available, suited to the level of care provided and following the residents' needs, including for YPD and mental health residents. Care is provided in the least restrictive and intrusive way. The service operates in conjunction with the police and social service departments, mental health services, churches, and other local district health boards in promoting acceptance, inclusion, mental health awareness, reducing stigma and discrimination in the process.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low	Planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. A resident profile is completed for each resident within two weeks of admission in consultation with the family where required. The activity programme is formulated by the activities staff. The activities are varied and appropriate for residents assessed as requiring a rest home, hospital, dementia, and psychogeriatric level of care. Residents who are under 65 years and those in the mental health unit attend to activities of their choice and are supported to attend to activities outside the facility as required. Residents' files had a documented activity care plan that reflected their preferred activities of choice; however, evaluations were not in sync with interRAI assessments (Refer 1.3.3.1). All residents in different services provided by the facility have a twenty-four-hour diversional therapy care plan in place. The files sampled in the mental health and psychogeriatric unit confirmed the use of the strength recovery model. Activity progress notes and activity individual participation records are completed daily. The residents were observed participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents and family members reported overall satisfaction with the level and variety of activities provided. Activities staff were not adequate to cover all number of services at the facility.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is documented on each shift by care and nursing staff in the progress notes. All noted changes by the health care assistants were reported to the nursing team in a timely manner. Formal care plan evaluations were not occurring following interRAI assessments to measure the degree of a resident's response about desired outcomes and goals every six months (Refer 1.3.3.1). The evaluations are carried out by the RNs in conjunction with family, residents, GPs', and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan. Short-term care plans were reviewed regularly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents, family members, clinicians, and other stakeholders were included and informed of all changes. Outcomes are measured through, achievement of set recovery goals, sadness depression assessment chart, Montreal cognitive assessment tool, mood scale, and MDT meetings that are conducted six-monthly.
Standard 1.4.2:	FA	A current building warrant of fitness which expires 22 June 2022 is publicly displayed. There have been no changes

Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		to the facility footprint since the previous audit.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. The CSM reported that an infection control form is completed when a resident has an infection. The infection is recorded in the infection prevention control register, and this was verified in documents sighted. A report is presented to the management and staff monthly. Staff interviewed reported that they are informed of infection rates at monthly staff meetings, quality meetings, and through compiled reports. The GP and NP are informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection. There was a norovirus infection outbreak on 30 June 2020 which was managed according to policy. The facility was closed to the public coincidentally it was during the Covid-19 alert level 4 lockdown. The NP, GP, family/whānau, residents, and relevant authorities notified in a timely manner. Documented statistics of staff and residents affected were sighted. The staff interviewed demonstrated an understanding of the infection prevention and control programme. There was a pandemic outbreak plan in place. Information and resources to support staff in managing Covid-19 were regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by the MOH were documented.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The organisation has policies and procedures in place governing the safe use of restraint and enablers which meet the requirement of restraint minimisation and safe practice standards. The restraint coordinator has designated responsibility for restraint and demonstrated a sound understanding of the organisation's policy and practices. A job description was available for this role and training is provided. The restraint register is maintained and evidenced that three enablers are currently in use and six restraints are in use. The organisation (HLL) has a national restraint approval group (RAG) which meets six monthly to review all restraint and enabler use and also considers how to minimise use. Restraint is not used as a preferred option but as a last resort to maintain safety of residents. Enablers are used in a voluntary capacity only for residents to promote safety at the request of the individual resident.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.	PA Low	Initial care plans were completed on admission in a timely manner using information from the discharge summary, initial and NASC assessments. Residents’ care plans were completed within three weeks of admission along with interRAI assessments. Evaluation of long-term care plans and activities care plans were not occurring at the same time with interRAI assessments.	Four out of eight long-term care plans and activity plans were evaluated without interRAI assessment outcome input.	Provide evidence that long-term and activity plans are evaluated/reviewed following interRAI assessments. 180 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain	PA Low	Activities are conducted by a registered diversional therapist (DT) another DT and an activities assistant; however, the staffing was not adequate to cover all services at the facility. There are currently three activities staff responsible for providing and implementing the activities programme but	There were not enough hours provided to	Ensure there are adequate hours provided to cover the activities

strengths (skills, resources, and interests) that are meaningful to the consumer.		due to the number of services provided the activities hours do not cover adequately this component of service delivery. The activities assistant was conducting combined daily activities for the rest home and dementia unit, the other DT was covering the mental health and psychogeriatric unit, while the other DT was responsible for the hospital wing and sometimes helping out in the secure units.	cover the activities programme in all areas of service delivery.	programme in all areas of service delivery. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.