# Beetham HealthCare Limited - Beetham Healthcare

## 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 BSI Group New Zealand Ltd, 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Beetham HealthCare Limited

**Premises audited:** Beetham HealthCare

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 21 June 2021 End date: 22 June 2021

**Proposed changes to current services (if any):**

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

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

Beetham HealthCare provides rest home, hospital and dementia level care for up to 48 residents. On the days of audit there were 44 residents. The service is managed by a general manager who is supported by a clinical nurse manager and a quality and human resources manager.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the nurse practitioner.

The residents and relatives interviewed spoke very positively about the care and support provided.

This audit identified the service is meeting the health and disability standards.

## 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. |

Beetham HealthCare practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is information available about the Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided, and individual values and beliefs are considered on admission and continuing through the care planning process. There is an open disclosure policy that staff understand. Family/friends can visit at any time and ongoing involvement with community activity is supported. Complaints processes are implemented, and complaints and concerns are managed and documented.

## 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. |

The board of directors have strategic business and annual quality goals with quality objectives. Quality information is reported to monthly staff and management meetings. The service has ongoing quality projects to improve outcomes and service delivery for the residents. Staff interviewed confirmed they are kept informed on risk management matters, outcomes of internal audits and receive meeting minutes. The service has comprehensive policies/procedures to provide rest home, hospital and dementia levels of care. There is an orientation programme in place and an annual education programme in place that includes compulsory training for aged care staff. There are documented job descriptions for all positions, which detail each position’s responsibilities, accountabilities and authorities. There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. There are registered nurses on duty 24 hours.

## Continuum of service delivery

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| 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. |

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted nurse practitioner (NP), general practitioners, and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants responsible for the administration of medicines complete education and medication competencies. The electronic medication charts (Medimap) are reviewed three monthly by the nurse practitioner and/or GPs.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. This includes a dementia-specific activities calendar and the provision of a range of activities for younger disabled residents, including education, leisure and cultural events as part of a plan developed in partnership with the resident. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

## Safe and appropriate environment

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

The building holds a current warrant of fitness. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances.

Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

## Restraint minimisation and safe practice

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| 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. |

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. There were five residents voluntarily using enablers and four residents had restraint used for them on the day of audit.

## Infection prevention and control

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

The infection control programme is appropriate for the size and complexity of the service. There is an infection control team that includes a shared infection control coordinator role, management and staff representatives. The Quality & HR manager along with the IC coordinators are responsible for coordinating and providing education and training for all staff. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control team uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility (including readiness for a pandemic), hand hygiene and surveillance of infection control events and infections.

## 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 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 101 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Beetham HealthCare practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and posters of the Code are displayed at the front entrance. The policy relating to the Code is implemented and staff interviewed (three registered nurses, six healthcare assistants and one diversional therapist) could describe how the Code is incorporated in their everyday delivery of care. Non clinical staff interviewed (a chef, maintenance person and administrator) were also knowledgeable around resident code of rights. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. Written general and informed consents (part of admission agreement) reviewed in the seven resident files (two rest home, two dementia, and three hospital level, including one ACC and one YPD) were signed by the resident or their enduring power of attorney (EPOA).  Advance directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Healthcare assistants (HCAs) and registered nurses (RNs) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative’s lives.  There are short-term admission agreements available for respite residents. Seven resident files sampled have signed admission agreements. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Advocacy pamphlets are displayed in the front entrance of the facility. Healthcare assistants interviewed were aware of the residents’ right to advocacy services and how to access the information. Resident advocates are identified on admission. Interviews with residents and relatives confirmed that they are aware of their right to access advocacy. |
| 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 | The service maintains key linkages with other community organisations. Residents are invited to community functions and events. Visiting arrangements are suitable to residents and family/whānau. Families and friends can visit at times that meet their needs. Families interviewed stated they are always made to feel most welcome when they visit. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisational complaints policy states that the facility manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. Three of the management team and the receptionist have completed privacy training and are included in the investigation of complaints as relevant. There is a complaint register that includes relevant information regarding the complaint, acknowledgment within the required timeframe, investigation, outcomes, follow-up letters, offers of advocacy and resolution. There were nine complaints from October 2019 to date. Complaints information is in the information pack at entry. There were complaints forms and advocacy brochures available and a suggestions box at the front entrance. Management operate an open-door policy. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is available at reception. The facility manager or clinical nurse manager discusses aspects of the Code with residents and their family on admission. Four residents interviewed (two rest home and two hospital) and six relatives (one rest home, three hospital and two of dementia care residents) reported that the residents’ rights are being upheld by the service. Residents and family members interviewed stated they received sufficient verbal and written information to be able to make informed choices on matters that affect them. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The service value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Māori consultation is available through the cultural advisor for the service. The cultural advisor attends some staff meetings and provides education sessions for staff. Staff receive education on cultural awareness during their induction and at least two yearly. All healthcare assistants (HCAs) interviewed were aware of the importance of whānau in the delivery of care for Māori residents. There were four residents who identified as Māori on the day of audit. There is a generic Maori Health Care Plan, and this was referred to as appropriate for the individuals. The individual plans reflected what was relevant/important to the individual. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents’ care plans. Residents and relatives interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A staff code of conduct is discussed during the new employee’s induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with healthcare assistants (HCAs) confirmed their understanding of professional boundaries, including the boundaries of the HCAs role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Healthcare assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Six HCAs and three registered nurses (RNs) could describe how they build a supportive relationship with each resident. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The board of directors and management team are committed to providing services of a high standard, based on the service philosophy of care. Staff were observed during the day demonstrating a very caring attitude to the residents. Residents interviewed stated they are very happy with the level of care provided. The service has implemented policies and procedures that are developed and reviewed by a healthcare consultant. The policies and procedures meet legislative requirements. Staff receive a verbal handover along with a handover sheet between every shift that details any significant events. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families and the management team promotes this. The information pack contains a range of information regarding the scope of service provided to the resident and their family on entry and any items they must pay for that is not covered by the agreement.  The information pack is available and advised that this can be read to residents. Interpreter services are available as required. Relatives interviewed, stated that they are informed when their family member’s health status changes. Seventeen incident/accident forms reviewed all documented that families had been informed of incidents/accidents unless it had been requested otherwise. Discussions with HCAs and RNs identified their knowledge around open disclosure. Residents/family meetings are held every two months. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Beetham HealthCare is a 48-bed facility that provides rest home, hospital/medical and dementia level care. The service has 42 dual purpose beds hospital/rest home and a six bed secure dementia unit. Occupancy on the day of audit was 44 residents. There were six residents in the dementia unit and 38 residents in the dual purpose beds (twenty-one rest home [one on respite] and seventeen hospital level). One hospital level resident was YPD and two hospital residents were under ACC contracts (one of these was on respite). The balance of residents were under the ARCC.  Beetham Village and Beetham HealthCare are privately owned and governed by a board of directors. They employ a general manager to operate both the village and the health care facility. The general manager (non-clinical) has been managing aged care facilities for nine years and has management experience in the public service sector. She is supported by a full-time experienced clinical manager (CM) who has been in the role six years. A qualified quality and human resource manager supports the management team and coordinates staff education and quality systems.  The facility manager reports directly to the two monthly board meetings. There is a three-year strategic business plan that contains the vision, mission and values for Beetham HealthCare. The business plan is reviewed regularly by the board. The service has annual quality goals objectives and measures progress towards meeting the goals and objectives. Goals achieved for 2020 included above 94% resident/relative satisfaction from the annual survey.  The general manager has maintained at least eight hours of professional development annually including training on Health and Safety law, aged care and retirement village legal issues, privacy act training and managing medical incapacity, bullying and harassment. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During a temporary absence, the clinical manager or the quality and HR manager will cover the facility manager’s role. A senior RN provides cover for the clinical manager leave. The service has operational management strategies and a quality improvement programme to minimise risk of unwanted events. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There are organisational policies to guide the facility to implement the quality management programme including (but not limited to) quality assurance and risk management programme, management responsibilities, health and safety and infection control responsibilities and internal audit schedule. Quality information and data is discussed at the monthly staff meetings including health and safety, infection control, audit outcomes and any concerns/complaints. Staff interviewed stated they are well informed and receive quality and risk management information such as a monthly adverse event summary. All events are entered into the health care consultant’s database and trended against industry key performance indicators. The HCAs interviewed stated they are asked for suggestions and feedback on quality initiatives.  An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed.  The quality and risk management programme includes health and safety and hazard identification. Staff report any hazards identified on the relevant form. The service has a health and safety representative (DT) who has completed health and safety representative training. There is a Health & Safety committee which includes the general manager, quality & HR manager, clinical nurse manager, housekeeper and maintenance person, this committee meets monthly and oversees all health and safety activities. Health and safety and emergency management training is included in the annual training plan and has been undertaken. The hazard registers have been reviewed six-monthly with generic hazards and work area specific hazards.  Falls prevention strategies are in place for individual residents that includes the analysis of falls and any areas for improvement.  Resident/relative satisfaction surveys are completed annually. The survey results are collated to identify if there are any areas for improvement and fed back to participants. The resident survey completed November 2020 showed 96% of respondents rated their care as either very good or excellent. Any comments made on survey are followed up by actions to further improve the service. |
| 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 | There is an accident/incident policy, which is part of the risk management plan. Monthly data collection of accident/incidents is completed. When an incident occurs, the staff member discovering the incident completes the accident/incident form and this is entered into the electronic data system by the clinical manager. The incident/accident and progress notes evidence timely RN clinical assessment and identifies preventative and corrective actions. All incidents/accidents are signed off by the general manager/clinical manager, who conducts a further investigation if required. Seventeen incident/accident forms for April 2021 evidenced detailed investigations and corrective action plans following incidents. Two unwitnessed falls were followed up with evidence of neurological observations being undertaken and recorded for a 24 hour period. There have been seven section 31 notifications to HealthCERT since the previous audit (three pressure injuries- two were pre-admission, three incidents of a resident wandering, one of theft and one relating to potentially unsafe use of a mobility scooter – police were involved). |
| 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 | There are human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (two HCAs, one RN, one diversional therapist, one maintenance person and one chef). The recruitment and staff selection process requires that police vetting, and reference checks are completed prior to employment to validate the individual’s qualifications, experience and suitability for the role. All files evidenced a signed employment contract and job description. Staff files reviewed had annual performance appraisals completed where due. Annual practicing certificates for RNs and allied health practitioners are all current. There is an orientation programme in place and staff are orientated to their area of work and complete competencies relevant to their role including medication and wound competencies.  The quality/HR manager is a Careerforce assessor and coordinates training for all staff. A training day covering mandatory training requirements is held regularly and staff are allocated to attend the study day (in 2020 there was one in March, July, September and November. In 2021 there was one in May and July with two more scheduled). Additional training includes manual handling with the physiotherapist, palliative care with the hospice and in 2020/2021 there has been considerable infection prevention and control training delivered. Competencies are identified and completed. Registered nurses and HCAs are encouraged and supported to undertake external education as offered. There were two career force assessors onsite and staff were progressing well with attaining level 4 qualifications. Four of seven registered nurses are trained in interRAI assessments.  Eight HCAs are employed in the dementia unit. Five HCAs have completed the required dementia standards. Three HCAs have been working in the dementia unit less than six months and are registered to commence the dementia standards. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staffing rosters were sighted and evidenced that staff that are sick and staff on annual leave are replaced. There is a full-time clinical manager on Monday to Friday and on-call. There is a registered nurse on duty 24 hours who also oversees the care for the dementia unit residents (six RNs have the allocation of one dementia resident each to check on and undertake required paperwork for). An HCA is on duty 24 hours a day in the dementia care unit with support provided from the rest home/hospital. There is an integrated roster for the rest home and hospital beds; on the morning shift, there are seven HCAs on duty (some shorter duties). Afternoon shifts are staffed with four HCAs on the full shift and one short shift plus one in dementia. On night shift, there are two HCAs with the RN in the rest home/hospital and one HCA in the dementia unit. With the addition of five dual purpose beds in 2020 there was considerable RN, cleaning, HCA and kitchen staffing hours added.  The facility manager/clinical manager are on duty Monday to Friday. There are dedicated laundry/cleaning staff. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a secure office in all areas and require password access to the electronic files. The clinical files are electronic. Monitoring charts are paper and remain with the resident. Progress notes are completed for each shift. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required, with evidence kept on file (sighted). The general manager and clinical nurse manager (CNM) screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. Information related specifically to the Nolan wing dementia unit also forms part of the information pack, which outlines access, assessment and the entry screening process.  The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The seven admission agreements reviewed meet contractual requirements and were signed and dated. Exclusions from the service are included in the admission agreement.  Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the general manager and clinical nurse manager are available to answer any questions regarding the admission process. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. The DHB ‘yellow envelope’ initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Healthcare assistants interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission into the facility. |
| 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 are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. A visit to the resident’s room evidenced safe storage. A self-medication assessment had been undertaken and signed by both the registered nurse and NP. All legislative and policy requirements had been met. There are no standing orders in use. There are no vaccines stored on site.  All clinical staff (RNs, EN and med-comp HCAs) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration.  The service currently uses robotics for regular medication and ‘as required’ medications. All medications are checked on delivery against the medication chart (MediMap) and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication rooms. The medication fridge temperatures are monitored daily and were within the acceptable range. The medication room has an air conditioning unit set to 21 degrees Celsius, with the room temperature being monitored daily.  All medications including the bulk supply order are checked weekly. All eyedrops have been dated on opening.  Staff sign for the administration of medications electronically. Fourteen electronic medication charts were reviewed. The medication charts reviewed identified that the GP and/or NP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. ‘As required’ medications had indications for use charted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The chef oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised and a current approved food control plan was in evidence, expiring December 2021. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.  There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. There is a procedure and policy for kitchen fridge and freezer temperatures to be monitored and recorded daily. Food temperatures are checked at all meals. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents’ dietary needs have been communicated to the kitchen using a printed dietary profile from the electronic resident management system. Special diets and likes and dislikes are detailed on this dietary profile, a copy of which is kept by the kitchen for each resident, these are also detailed on a whiteboard within the kitchen. The four-weekly seasonal menu is approved by an external dietitian.  Residents and families interviewed described the food as ‘extraordinary’ and ‘beautiful’. Additional snacks and finger foods are available at all times. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents’ files reviewed apart from the YPD resident. Six monthly interRAI assessments and reviews were evident for four of seven resident files sampled, as one hospital resident was ACC respite and one YPD. One rest home resident had not been in the service for six months.  Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the speech and language therapist, dietitian, district nursing service and stroke communication group. The healthcare assistants interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident’s condition changes, the RN will initiate an NP and/or GP consultation. Staff stated that they notify family members about any changes in their relative’s health status. Care plans have been updated as residents’ needs changed.  Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.  Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of residents’ dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.  Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included; one contusion, two skin tears, two dermatitis, and one grade 3 pressure injury (community acquired). There was evidence of district nursing specialist involvement in chronic wound management.  Monitoring forms are in use as applicable, such as weight, vital signs and wounds and neurological observations. |
| 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. | FA | There is one diversional therapist, and one activities coordinator who plan and lead all activities. The activities programme operates seven days per week. Residents were observed participating in planned activities during the time of audit.  There is a weekly programme available in large print distributed to all residents. This is also written on whiteboards in all areas of the facility.  Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) floor games, happy hour, crafts, quizzes, and visiting entertainers.  Residents in the memory loss unit are brought out to integrate and participate with the other residents in the main facility under the supervision of the diversional therapist. Those residents who prefer to stay in unit or cannot participate in the group activities on that day have one-to-one support from an HCA in the unit.  There are weekly morning teas with other nearby facilities and a competitive bowls competition against other rest homes on a monthly basis. Other community outings occur weekly.  There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers’ Day and Valentine’s Day are celebrated. There are visiting community groups such as cultural dance groups, churches and children’s groups.  The YPD resident has an individualised, age-appropriate activity plan which includes the use of a tablet to contact family, attendance at a stroke group and one-on-one/gym sessions.  Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career and family. Activity plans are comprehensively documented in great detail on the electronic resident management system and are evaluated at least six-monthly at the same time as the review of the long-term care plan.  Residents interviewed were very positive about the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long term care plans are evaluated by the RNs six monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six-monthly care plan review is also completed by the registered nurse with input from HCAs, the NP/GP, the diversional therapist, resident (if appropriate) and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the NP/GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurses interviewed could describe the procedure for when a resident’s condition changes and this was evidenced for a resident file sampled who was admitted to hospital and then had their plan of care updated on their return. Discussion with the clinical nurse manager and registered nurses identified that the service has access to a wide range of support either through the NP, GP, specialists and allied health services as required. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a building warrant of fitness which expires July 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.  Electrical equipment has been tested and tagged, expiring June 2022. The hoist and scales are checked annually and are next due to be checked March 2022. Hot water temperatures have been monitored in resident areas and are within the acceptable range.  Flooring is safe and appropriate for residential care.  The facility has sufficient equipment to allow personal, rather than communal use and includes items such as walkers, wheelchairs and hoist slings. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.  The external areas and decked areas are well maintained. All external areas have attractive features, including flower beds, rose garden, and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.  The memory loss unit provided an open plan dining/lounge area with free and safe access to an outdoor courtyard with gardens, seating and shade. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Toilet and shower facilities are of an appropriate design to meet the needs of the residents. All rooms apart from two have full ensuites and there are adequate numbers of communal toilets in each wing. The two rooms without ensuites share a bathroom adjacent to the rooms. Privacy is assured with the use of ensuites and communal toilet/bathroom facilities have a system that indicates if it is engaged or vacant.  Fixtures, fittings, floorings and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within the safe range as per current guidelines and legislation. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Bedrooms have external windows allowing adequate light and ventilation. Residents and families are encouraged to personalise their rooms. This is evident on audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The facility has a large lounge/dining area for the rest home and hospital residents, which is divided into a number of areas for dining, and seating is placed to allow for individual or group activities.  There is a separate large activities room/chapel. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. Space and privacy are afforded to younger disabled persons within the service within these communal areas. All furniture is safe and suitable for the residents. The communal areas are easily accessible.  The memory loss unit has a spacious open plan dining/lounge area with seating placed appropriately to allow for low stimulus, small group and individual activities. The communal areas are easily and safely accessible for residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are designated cleaning staff seven days a week. Cleaning trolleys are well equipped and kept in locked areas when not in use. There are cleaning and laundry manuals available. Cleaning and laundry services are monitored through the internal auditing system.  All personal clothing and linen are laundered on site with the laundry having an entry and exit door with defined clean/dirty areas.  Sluice rooms were kept locked when not in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. There are adequate civil defence supplies including water and food storage. There is a battery backup in the event of a power failure and the service has a contract with a supplier for a generator in the event of a power failure.  The fire evacuation scheme was approved by the fire service on 30 September 2009. There are six monthly fire drills. Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.  Residents’ rooms, communal bathrooms and living areas all have call bells. Security policies and procedures are documented and implemented by staff. The buildings are secure at night.  Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months and there is a New Zealand Fire Service approved evacuation scheme.  The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures including resident evacuation should this become necessary. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.  There are adequate supplies available in the event of a civil defence emergency including water, food and supplies (torches, radio and batteries), emergency power and barbeque, these are checked monthly. The facility keeps sufficient emergency water for 3 litres per person, per day for at least 3 days for resident use on site. A gas cooker is available on the premises and a generator is available locally for facility use in case of prolonged power outage.  Residents’ rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on display panels, light outside the resident’s room and also give an audible alert. Residents were observed in their rooms with their call bell alarms in close proximity.  There is always at least one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate.  Security policies and procedures are documented and implemented by staff. The buildings are secure at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the Infection Control Coordinator (ICC). This role is shared by the Clinical Nurse Manager (leads) and a registered nurse who have both recently undertaken the Ministry of Health infection control coordinators online training. The ICC has a signed job description. The infection control programme is linked into the quality management programme. Infection reports are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place that are appropriate to the complexity of the service provided.  Infection control data is discussed at the monthly meetings. Monthly and annual comparisons are made for the type and incidence of infection rates. Internal audits for infection control are included in the annual audit schedule. The service is benchmarked against other similar services through the aged care consultant database. Visitors are asked not to visit if they are unwell. Influenza and covid vaccines are offered to residents and staff. Hand sanitizers are available throughout the facility. Visitors make a wellness declaration and details are retained for the purposes of tracking and tracing if necessary. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The service is affiliated with an external aged care consultant for any advice or updates for policies.  The infection control coordinator provides monthly reports to management and staff meetings. The ICC has access to an infection control nurse at the Tairawhiti District Health Board (TDHB). The TDHB IC nurse specialist recently undertook an audit at Beetham Healthcare to determine the services preparedness should there be a Covid19 outbreak and determined the facility was well ready with equipment, training and the plan for an isolation unit – an additional activities room and resident gym would become the isolation unit. In the 2020/21 period there have also been zoom meeting with TDHB staff re Covid19. The regional medical officer of health has also visited the site to talk with management reducing risks of Covid19. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. The infection control policies (last reviewed by an aged care consultant in 2020/2021 with more information in response to Covid) link to other documentation and cross reference where appropriate. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating and providing education and training to staff. The orientation package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs, and planned sessions have been held on five occasions in 2020 and in May 2021. Each staff member has their hand hygiene knowledge/competence checked annually. |
| 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 | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection reports are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place, that are appropriate to the complexity of service provided.  Infection control data is discussed at the monthly meetings. Monthly and annual comparisons are made for the type and incidence of infection rates. Internal audits for infection control are included in the annual audit schedule. The service is benchmarked against other similar services through the aged care consultant database.  Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. The service currently has four residents assessed as requiring the use of restraint (bedrails and chair belt) and five residents using enablers (bedrails). There is a restraint coordinator (clinical nurse manager) who reports to the monthly RN meetings (minutes of May & June 2021 meetings evidenced same). There is documented evidence of consultation with the resident and family/whānau regarding the use of enablers and of family, GP/NP, restraint coordinator and RN for the use of restraint. Three resident files of those using enablers evidenced voluntary request and consent to enabler use. Three files of residents restrained evidenced that appropriate assessment, consenting and monitoring was occurring. Risks were documented in all care plans.  Staff receive training around restraint minimisation on orientation and as part of the annual education programme. |
| Standard 2.2.1: Restraint approval and processes  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. | FA | The clinical nurse manager is the restraint coordinator. Assessment and approval process for restraint use includes the restraint coordinator, registered nurses, resident/or representative and medical practitioner/nurse practitioner. The restraint coordinator had a signed job description. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint assessments are based on information in the care plan, resident discussions and on observation by staff. There was a restraint assessment tool completed for the residents requiring restraint. Ongoing consultation (as appropriate) with the resident/EPOA is identified. Falls risk assessments are completed six monthly and interRAI assessment identifies risk and need for restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process, as part of the restraint minimisation policy that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used.  The care plans of three of the four residents with restraint identified observations and monitoring. Restraint use is reviewed through the monthly RN meetings and six monthly assessment/evaluations and multidisciplinary meetings. A restraint register is maintained. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Evaluation has occurred six monthly as part of the ongoing reassessment of the residents on the restraint register, and as part of their care plan review. The family is included as part of the MDR. Evaluation timeframes are determined by policy and risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Individual approved restraint is reviewed at least monthly through the RN meeting. The scheduled audits on restraint practices had been undertaken in January and May 2021. No corrective actions were required. |

# 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.

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# 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.

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End of the report.