

Heritage Lifecare Limited - Stillwater Gardens Lifecare

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 Limited
Premises audited:	Stillwater Gardens Lifecare
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: 23 September 2021 End date: 24 September 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:	67

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Stillwater Gardens Lifecare (Stillwater) is operated by Heritage Lifecare Limited and certified to provide rest home care, hospital level care (including long-term support for chronic health conditions), respite, dementia care, and short-term day care for up to 69 residents. The service is also certified to provide disability support services for residential long-term care residents under a Ministry of Health (MoH) contract.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board and MoH. The audit process included review of policies and procedures, review of residents' and staff files, observations, and interviews with residents, family/whānau members, managers, staff, contracted allied health providers and a general practitioner.

This audit has identified areas requiring improvement relating to corrective action planning, adverse event reporting, care planning, service delivery intervention, and activity care planning and delivery. The areas related to care planning and service delivery interventions identified at the previous audit as requiring improvement were again identified in this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families/whānau are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and the Nationwide Health and Disability Advocacy service. The information is brought to the attention of prospective residents prior to their entry into the facility and is available within the facility after admission. There are opportunities for residents and their families/whānau to discuss the Code on admission and as required. Open communication between staff, residents and families/whānau is promoted to some extent, though some dissatisfaction with communication from management was expressed by some of the residents and family members interviewed.

The rights of residents and/or their family/whānau to make a complaint is understood, respected, and upheld. The Care Home and Village Manager is responsible for the management of complaints with support from the Heritage Lifecare support office. Concerns and complaints are documented, addressed, and resolved promptly. There is a register for complaints that is shared with the support office, and this is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Heritage Lifecare is the overarching governing body responsible for the services provided at Stillwater. Business, quality, and risk management plans relevant to Stillwater are in place. The business plan included the scope, direction, goals, and values of the organisation.

Service monitoring to the Heritage Lifecare support office is regular and effective allowing Stillwater to benchmark against other Heritage Lifecare facilities. Adverse events, including incidents, accidents and hazards are documented with corrective actions implemented. Appropriate statutory and regulatory reporting was evidenced. Policies and procedures support service delivery and were current and reviewed regularly.

The quality and risk management system supports the provision of clinical care and includes collection of quality improvement data. The system identifies corrective action arising from internal audits. Quality and risk trends are identified, and staff reported that they had input into quality improvement activities.

The service is managed by the Home Care and Village Manager who is experienced and suitably qualified. The manager is supported in the role by a clinical services manager who is responsible for the oversight of clinical services provision in the facility.

Staffing levels are adequate and meet contractual requirements across the service; however, a number of the registered nurses lack experience in the aged-care sector. Staff spoke positively about the service and the support they receive from each other and the management team. Registered nurses (RNs) are on duty 24 hours a day, seven days a week. They are supported by allied health staff. On-call support arrangements are in place for the RNs.

Human resource policies were current and implemented. The appointment, orientation and management of staff is based on current good practice. There is a systematic approach to identify and deliver ongoing training to support safe service delivery and individual performance reviews are carried out.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are based on a range of information. Short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being kept informed.

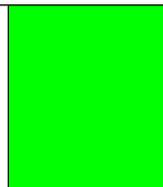
The planned activity programme is developed by two diversional therapists and provides residents with a range of activities. A facility van is available for outings.

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

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

Safe and appropriate environment

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

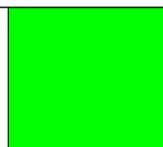


Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness and emergency evacuation plan.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. A comprehensive assessment, approval and monitoring process with regular reviews is in place. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes and education on restraint minimisation and safe practice is part of the education programme. There were no residents using restraints or enablers at the time of audit.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken. Data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	2	3	0	0
Criteria	0	38	0	2	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation's complaints/concerns policy and forms are in line with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include timeframes for responding to a complaint. Feedback forms for compliments, concerns and complaints were observed to be available in the facility alongside advocacy information, and residents and their family/whānau are given information on complaints and advocacy in an information folder prior to admission.</p> <p>Most of the residents and family/whānau interviewed reported that, while they were not sure where complaints forms were kept, they felt confident that they would know how to make a complaint should they need to. Two residents and four family/whānau members interviewed said that they were unsure how seriously their complaints were being taken (refer 1.2.3), but the complaints register showed that any complaints that had been received from complainants had been documented and addressed.</p> <p>The complaints register reviewed showed that 12 complaints have been received over the past year. Actions taken, through to an agreed resolution, are documented and completed within the timeframes in most cases. One complainant has taken their complaint to the Office of the Health and Disability Commissioner (HDC). While this complaint remains open, the response from Stillwater has been sent to the Commissioner's office. For the remainder of the complaints, action plans show any required follow up, any improvements that have been made as the result of the complaint and outlined the escalation pathways open to complainants. A previous complaint to the Health and Disability Commissioner from 2019 has been closed with no corrective action identified.</p>

		<p>The Care Home and Village Manager (CHVM) is responsible for complaints management and follow up with the support of the Heritage Lifecare support office. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from any other external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy that sets out the process to guide staff and ensure that there is disclosure of any adverse event where a resident has suffered unintended harm while receiving care. Documentation demonstrated that adverse events and changes in health status are appropriately reported to family/whānau. Staff understood the principles of open disclosure.</p> <p>There are monthly residents' meetings to inform residents of facility issues, events and activities. The schedule has been mostly adhered to but has been affected by gastrointestinal outbreaks and Covid-19 lockdowns in the facility over the last year. Meetings provide attendees with an opportunity to make suggestions, provide feedback; and raise and discuss any issues. Minutes sighted confirmed that residents are given the opportunity to raise any issues and have them addressed. Families/whānau are welcome to attend.</p> <p>Communication between staff and residents and their families/whānau was observed to be positive throughout the audit, however, resident and family interviews (refer 1.2.3) reported that they feel that sometimes the management is not listening to their concerns.</p> <p>Interpreter services were available as required through the Nelson Marlborough District Health Board (NMDHB). There were no residents who required interpreter assistance on the days of the audit and the manager reported that interpreter services are rarely required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Stillwater is part of the Heritage Lifecare Group. The company's executive management team provides support to the facility and have access to Stillwater's business and quality information. The business plan is reviewed annually and outlines the purpose, values, scope, direction, and goals of the organisation. The documents described annual and longer-term objectives and associated operational plans. A sample of monthly reports to the Heritage Lifecare support office showed adequate information to monitor performance is reported including financial performance, emerging risks and issues, staffing, and staff performance.</p> <p>The service is managed by a CHVM who has 38 years in the industry, has a relevant qualification in management, and has been in the role for 15 months. The clinical service manager (CSM) has recently been appointed (eight months ago) but has worked as a registered nurse for 12 years and has a current practising certificate. The CSM has a Bachelor of Nursing and is currently studying for a Master of Nursing specialising in Gerontology. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements. The CHVM and CSM confirmed knowledge of the sector, regulatory, and reporting requirements and that they maintain</p>

		<p>currency through engagement with other Heritage Lifecare facilities at management and clinical management meetings and through the DHB.</p> <p>The service holds contracts with the DHB for aged-related residential care (ARRC), long-term chronic health conditions (under 65), dementia care (D3), respite, and day care services. A contract via the Ministry of Health (MoH) is also held for disability support services for residential care – non-aged (under 65). On the day of audit there were 67 residents; 51 residents were receiving services under the ARRC contract (hospital and rest home level care), 15 under the dementia care contract, and one under the MoH disability support service contract. One of the residents in the secure dementia unit is assessed as requiring hospital level care and has a dispensation from the MoH (sighted) to allow him to remain as a resident in the stage 3 dementia care unit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of adverse events, monitoring of outcomes of clinical incidents, including infections and wounds, complaints, audit activities, a regular resident and family/whānau satisfaction survey, and a staff satisfaction survey. Benchmarking against other Heritage Lifecare facilities takes place and results from the benchmarking are generally at or above expected levels.</p> <p>The service implements policies and procedures to support service delivery. They are reviewed in a timely manner and were current. Policies are linked to the Health and Disability Sector Standards, current applicable legislation, are evidence based and include reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The document control system ensures a systematic and regular review process, referencing of relevant sources, and approval.</p> <p>The manager is familiar with the Health and Safety at Work Act (2015) and has implemented its requirements.</p> <p>Meeting minutes reviewed confirmed regular review of quality indicators and that related information is reported and discussed at the health and safety, registered nurse (RN), staff, and resident/whānau meetings. Staff interviewed reported their involvement in quality and risk management activities through audit activities and reporting at staff meetings.</p> <p>Internal audits are completed as scheduled. Corrective actions are identified but (except in one instance), there was no documented action plan to address deficits identified as corrective actions, and no 'sign-off' to indicate that the deficit had been resolved. The manager of the service was not aware that the audit requirements were not being fully completed and the CSM who was primarily tasked with doing the audits was unaware that they were incomplete and had not addressed the issues identified. This will need to be addressed by the service to ensure internal audits are relevant and used as a learning/correction tool to check on and improve services.</p> <p>Resident and family/whānau satisfaction surveys are completed annually. The most recent survey undertaken in 2021 showed that residents (24) and their families/whānau (10) who responded were positive about the service. However, some comments from residents and family/whānau interviewed on the day of audit did not correlate with</p>

		<p>this result. Two of five residents and four of eight family/whānau members interviewed expressed dissatisfaction with the service (all from the hospital level care area of the facility). Concerns related to communication around the continuum of care and lack of activity opportunities for residents; these were supported through examination of information of residents' files, observation and on interview (refer criteria 1.3.5.2, 1.3.6.1, and 1.3.7.1).</p> <p>Staff satisfaction surveys are conducted every two years. The last survey was conducted in 2019, it was sent to 90 staff and generated 31 responses (34% response rate). The results of this survey showed that staff are generally positive about the service especially in the areas of engagement, leadership, and organisational change with some negativity in the areas of engagement (even split between positive and negative) and organisational values. This was supported by the staff interviewed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>Staff document adverse and near miss events on an accident/incident form. Over the past year, there has been an average of 11 incidents per month, primarily falls, falls with injury (e.g., fracture, skin tear), absconding from the facility, and incidents resulting from resident behaviour. A sample of six incidents reviewed (2 falls, 1 fall with a fracture, 2 from residents exhibiting challenging behaviour, and one related to a resident absconding from the facility) showed that actions in respect of these were fully completed. Incidents were investigated and openly disclosed to family/whānau as appropriate, action plans were developed, and followed-up in a timely manner. Where appropriate these were notified to relevant authorities. Adverse event information gathered is regularly shared at facility meetings with incidents collated, trends analysed, and benchmarking of data across other Heritage Lifecare facilities.</p> <p>The CHVM described essential notification reporting requirements, including for pressure injuries, however a section 31 notification of the stage three pressure injury which had been present prior to the audit was submitted to the Ministry of Health (MOH) on the day of audit. There have been 36 other notifications of significant events reported to the Ministry of Health in 2021. These relate to falls with fracture (14), a fall with head injury, resident behaviour (12), resident absconding (six), an alleged sexual result (identified as delirium), and gastroenteritis outbreak (two - also notified to public health). All have been acknowledged by the MoH.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records are maintained. The skill and knowledge requirements for staff are documented in job descriptions.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Eight staff records reviewed (two RNs, three caregivers, one diversional therapist, one cleaner, and one laundry staff member) showed documentation of completed orientation and a performance</p>

<p>good employment practice and meet the requirements of legislation.</p>		<p>review after a three-month period (except in two instances, one due to ongoing sick leave over the period and the other as they are a recent employee). Staff performance appraisals are carried out annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements, such as manual handling, infection control, emergency management and restraint minimisation and safe practice. Care staff have access to a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. All staff working in the dementia care area have completed the required education for the service. The CSM is the internal assessor for the education programme. Records reviewed demonstrated completion of the required education/training for the various staff roles including interRAI assessments, medication competency, first aid, and syringe driver competency.</p> <p>There are sufficient RNs across the facility who are maintaining their annual competency requirements; three of whom undertake interRAI assessments. Orientation for new RNs has been completed, but as noted in 1.2.8, a number of these RNs are new to the industry and inexperienced in the aged-care sector. They are being supervised and mentored by the CSM but, while she is an experienced RN in the aged-care sector, she is new to the supervisory role (8 months) and to management. One of the general practitioners (GPs) interviewed made mention of the number of new RNs at Stillwater and expressed concern around RN assessment skills when she is contacted by them for acute concerns. RN inexperience may be a factor in the deficits identified in care planning and care interventions during this audit (refer 1.3.5.2 and 1.3.6.1) but, given the nationwide shortage of experienced RNs in New Zealand currently, it is difficult to see how this can be rectified in the short term.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them and rosters reviewed showed that staff are replaced to cover unplanned absences. Residents and family/whānau interviewed supported this. Observations and review of a four-week roster cycle confirmed sufficient staff cover has been provided, with staff replaced in any unplanned absence. RN availability has been problematic due to attrition and movement within the sector (e.g., to the DHB). Stillwater has been able to maintain its rostered RN hours through the use of the CSM (who is an experienced RN) working 'on the floor' while new hires are orientated. The attrition has meant that there are fewer experienced RNs in the facility which could account for some of the issues noted in residents' documentation (refer 1.2.7, 1.3.5.2 and 1.3.6.1).</p> <p>The rosters reviewed showed that there are two RNs on a morning shift supported by 10 caregivers with two RNs and nine caregivers on the afternoon shift. Night shift is covered by one RN and four caregivers. The HCVM and CSM work 40 hours per week Monday to Friday. At least one staff member on duty has a current first aid certificate and there is 24 hour a day, seven days a week (24/7) RN coverage in the hospital.</p> <p>There are two diversional therapists (DT) who are employed to work across the facility, both are employed 40 hours</p>

		<p>per week, Monday to Friday. There are no DTs on site on the weekends unless a special event is planned. The roster sighted does not apportion DT time to specifically work in the dementia area and, given one of the DTs has been away for personal reasons between January to July this year and not replaced, the level of DT engagement in the facility and dementia unit has been lacking (refer criterion 1.3.7.1). Observation during the audit period allied to interviews with staff, residents, and their families/whānau confirmed this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>There are systems in place to allow for the self-management of medications for residents who were competent and wished to do so, including policy and self-medication processes and electronic monitoring by staff. There were no residents who were self-administering medications at the time of audit.</p> <p>Medication errors are reported to the RN and CSM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian 15 January 2021. Recommendations made at that time have been implemented.</p> <p>An up-to-date food control plan is in place, and a verification audit was undertaken 22 July 2021. No corrective actions were identified, and the plan was verified for eighteen months.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and in residents' meeting minutes. Areas of dissatisfaction were generally responded to, though in one instance a resident with weight loss had no management strategies documented (refer 1.3.5.2). Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p> <p>Residents in the secure unit always have access to food day or night.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>There were nine care plans reviewed during the audit. Three of the nine files reviewed, reflected fully the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed. Six of the nine files did not reflect fully the support needs of the residents. These care plans did not always evidence service integration with progress notes, activities note, medical and allied health professional's notations. This was a previous corrective action and ongoing attention is required.</p> <p>Any change in care required was documented in progress notes and verbally passed on to relevant staff.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	<p>PA Moderate</p>	<p>Documentation, observations, and interviews verified that the care provided to residents was not always consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was not evident in all areas of service provision. This was a previous corrective action and requires ongoing attention. The GP interviewed, verified that medical input is sought in a timely manner and that medical orders are</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>followed. Care staff confirmed that care was provided as directed by the RN. A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>On the day of audit, Stillwater verified it employs two diversional therapists (DTs) to provide the activities for residents in the hospital rest home and the secure unit. Interviews with the DTs identified recent gastric outbreaks and lockdowns had impacted on van outings and activities being offered at Stillwater. Interviews evidenced there was only one DT from January to July providing activities in all care areas at Stillwater. In July a second DT was employed; however, one was then absent for six weeks over August. One member of the activities team, on the two days of audit, was monitoring visitor entry to the facility, due to Covid-19 restrictions. On the second day the second DT was absent.</p> <p>During interview, the therapists said activities were generally provided in the rest home lounge and staff brought residents from the three care areas to participate.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated regularly and as part of the formal care plan review every six months.</p> <p>The planned monthly activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included 'bingo', bowls, card games, church services, singing visiting entertainers, quiz sessions and daily news updates.</p> <p>The activities programme is discussed at the residents' meetings and minutes indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with activities; however, on the days of audit, observation, resident, staff, and family interviews referred to minimal activities being offered at Stillwater. The residents in the secure unit had no activities plan in place that identified residents' twenty-four-hour needs. This is an area requiring attention. Rest home residents confirmed when activities are offered, they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>service is expected to respond by initiating changes to the plan of care, however in six of the nine residents' care plans reviewed, changes were not always fully described or were not consistent with the residents' needs (refer criteria 1.3.5.2 and 1.3.6.1).</p> <p>Short-term care plans when in place, were consistently reviewed for infections and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed.</p> <p>Residents and families/whānau interviewed provided some examples of involvement in evaluation of progress and any resulting changes, though one family/whanau member interviewed expressed concern about a breakdown in communication regarding pain and pain management for one resident (refer Standard 1.3.3).</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A building warrant of fitness is publicly displayed, issued on 9 August 2021.</p> <p>There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The environment was hazard free and resident safety is promoted.</p> <p>The testing and tagging of electrical equipment and calibration of biomedical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel, and observation of the environment.</p> <p>Staff reported that they had sufficient equipment to safely deliver care to residents. Hot water temperatures are monitored monthly with variances addressed by registered external contactors (gas system) if this is required. Documentation showed there had been no deviance requiring intervention.</p> <p>External areas are safely maintained and were appropriate to the resident group/s and setting. The dementia wing has an enclosed outside area available for use to maintain resident safety. The facility has sufficient space for residents to mobilise using mobility aids and areas that allow for residents and their family/whānau to have privacy.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family/whānau members interviewed were happy with the environment.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The CSM is the infection control nurse (ICN) and reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the</p>

<p>and methods that have been specified in the infection control programme.</p>		<p>surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers with results that are generally at or above accepted benchmarking levels.</p> <p>Stillwater had a gastroenteritis outbreak in June 2021, affecting eight residents and two staff. In July 2021 it had a Norovirus outbreak that affected 29 residents and one staff. Public Health and the NMDHB were informed of both outbreaks. The facility went into lockdown during both events. An analysis has resulted in increased hand washing audits and training.</p> <p>A good supply of personal protective equipment is available. Stillwater Gardens has processes in place to manage the risks imposed by Covid-19. With the present level 2 restrictions, Stillwater is limiting visiting hours and temperature checking all visitors and staff on entry to the facility. Masks are being worn by all staff and visitors.</p> <p>A Covid-19 management plan and a pandemic plan is sighted.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The CSM is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility demonstrating a sound understanding of the organisation's policies, procedures and practice, restraint management and the restraint coordinator's role responsibilities.</p> <p>Restraints are used only when clinically indicated and justified and de-escalation strategies have been ineffective. Enablers are voluntary and the least restrictive option to maintain independence and safety. On the day of audit, there were no residents using restraints or enablers.</p> <p>Interviews with staff showed that they understood de-escalation strategies and the difference between restraints and enablers. Restraint has not been used at the facility for at least five years but information on restraint minimisation and safe practice is included in orientation and in the ongoing education/training programme. This was confirmed through training records and through interviews with staff.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA</p> <p>Moderate</p>	<p>Corrective actions identified in relation to recorded concerns and complaints and incidents, accidents, and hazards were well managed.</p> <p>There is an internal audit schedule which is adhered to. Nine internal audits from 2021 were reviewed. These related to the promotion of continence (six corrective actions identified), pain management (one corrective action), falls management (four corrective actions), resident transfers and handling (one corrective action), infection control (100% compliance), personal protective equipment and outbreak toolkit (100% compliance), hand hygiene (100% compliance), environmental (two corrective actions), and hot water monitoring (100% compliance). In five of the audits, corrective action(s) were identified but, except in one instance (resident transfer and handling), there was no documented action plan to address deficits identified as corrective actions, and no ‘sign-off’ to indicate that the deficit had been resolved. This is of concern given four of the audits had 12 corrective actions identified which refer directly to resident care. The audit identified deficits in resident care (refer 1.3.5.2 and 1.3.6.1), and resident and family interviews outlined concerns that had not been picked up in the resident and family/whānau satisfaction survey.</p>	<p>Not all internal audit forms had a documented action plan to address deficits identified as corrective actions, and no ‘sign-off’ to indicate that the deficits had been resolved.</p>	<p>Internal audit forms are fully completed and show the action plan to address deficits identified as corrective actions, and these are signed off as completed when the issue has been resolved.</p> <p>90 days</p>

<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	<p>PA Low</p>	<p>Pressure injuries at stage three and above are required to be reported to the Ministry of Health. The resident was admitted to the facility from the hospital in 2020 with a stage 3 pressure injury which this was originally improving. The resident subsequently became very frail, and the injury started deteriorating; it became a stage 3 injury by August 2021. The injury was not reported to the Ministry of Health by the facility until the issue was identified during the audit process.</p>	<p>Stage 3 pressure injuries must be reported to the Ministry of Health in a timely manner.</p>	<p>Report all stage 3 pressure injuries to the Ministry of Health in a timely manner.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Six of the nine residents' files reviewed did not document fully the support the resident required to meet their needs. This specifically related to the nursing management strategies to manage residents' actual and potential medical conditions and changing needs. Three of the files had adequately documented residents' needs.</p> <p>A resident's behaviour management plan was implemented in April 2021 and has not been updated since, despite frequent episodes of aggression recorded in the behaviour management plan. This resident has an MOH dispensation in place to remain in the present care level; however, ongoing evidence was not sighted of a review of this placement. The resident's relative interviewed expressed that excellent care is provided at Stillwater; however, made comment regarding the minimal activities being provided (refer criterion 1.3.7.1).</p> <p>Residents with long term medical conditions (e.g., congestive heart failure, seizures and weight loss) had no management strategies documented. The hospital level care resident reviewed in detail using tracer methodology (referred to in 1.3.3), prior to the audit, had no plan in place to manage the pain. Additional documentation identifying the cares the resident requires to provide effective palliative care and optimise comfort (e.g., mouth cares) are not documented, though were</p>	<p>Six of the nine residents' care plans reviewed, did not describe fully the care required to meet the residents' desired outcomes.</p>	<p>Provide evidence that care plans describe fully the required support the resident requires to meet their needs.</p> <p>90 days</p>

		<p>provided when suggested.</p> <p>A resident on warfarin has no nursing strategies documented regarding managing the risk of anticoagulant therapy. Interviews with the RNs, confirmed the RNs are new to aged care and needed a high level of clinical guidance to ensure residents' needs are met.</p> <p>The assessment process had not alerted management to the deficits noted and they were unaware of the deficits until highlighted during the audit, The GP commented at interview on the lack of assessment skills of some of the nursing staff new to the facility (refer 1.3.3 and 1.2.7).</p>		
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Two residents' care plans described pressure injury management and a change in position regime. On the two days of audit this was observed not to occur. The residents were put in a comfy chair on wheels and remained in that chair, with no change in position or attention to personal needs all day. The repositioning chart on the day and previous days verified this.</p> <p>Prior to audit, the resident reviewed via tracer methodology, had no effective pain management provided, or requested, to ensure the resident's pain was managed effectively.</p> <p>A resident who was noted to be losing weight, had no interventions being implemented by nursing staff to minimise weight loss.</p> <p>Interviews with four of eight family/whānau members and two of four residents, expressed dissatisfaction with some aspects of the care provided at Stillwater.</p>	<p>The interventions provided to some residents at Stillwater are not always consistent with meeting the residents' assessed needs and desired outcomes. This, at times, is due to the care plan not documenting fully that care required (refer 1.3.5.2). Or, the care is documented, and not provided.</p>	<p>Provide evidence care plans describe fully the support the resident requires to meet their assessed needs, and that the required care is provided.</p> <p>90 days</p>
<p>Criterion 1.3.7.1</p>	<p>PA Low</p>	<p>Activities are not being provided on a regular basis at Stillwater to</p>	<p>Activities are</p>	<p>Provide evidence</p>

<p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>develop and maintain residents' strengths skills and interests. There was only one DT from January 2021 to July 2021 providing activities in all three services areas at Stillwater. In July a second DT was employed, however one was then absent for six weeks over August. One member of the activities team, on the two days of audit, was monitoring visitor entry to the facility. One was on leave on day two. Resident, family, and staff interviews evidenced minimal activities occurring in the secure unit and the hospital. A news reading session was observed in the rest home, with six residents in attendance on both days of audit. A DT was present in the secure unit over lunch; however, no activities were observed to be offered in the hospital and secure unit during the one-and-a-half-day audit.</p> <p>There is no twenty-four-hour activity plan in the secure unit that addresses the residents' twenty-four-hour needs.</p>	<p>planned, however they are not provided on a regular basis, to develop and maintain residents' skills, strengths, and interest.</p> <p>Residents in the secure unit have no twenty-four-hour activity plan in place.</p>	<p>activities are planned and provided to develop and maintain residents' strengths, skills, and interests. Provide evidence there is a designated person engaged in the secure unit who is skilled in the implementation and evaluation of diversional and recreational activities. Provide evidence that each resident in the secure unit has a twenty-four-hour activity plan that addresses their twenty-four-hour needs.</p> <p>90 days</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.