

Oceania Care Company Limited - Heretaunga Home & Village

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Oceania Care Company Limited
Premises audited:	Heretaunga Home & Village
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: 27 October 2021 End date: 1 November 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:	59

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

Heretaunga Home and Village provides residential services at rest home, dementia and hospital level care for up to 58 residents. There is also one independent resident under an Occupational rights Agreement. The facility is operated by Oceania Healthcare Limited and is managed by a business and care manager and a clinical manager.

Residents and families reported high satisfaction with the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, managers, staff, a general practitioner, nurse practitioner and an allied health professional.

A continuous improvement rating has been awarded relating to the management and prevention of pressure injuries.

There are no areas requiring improvement from 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.

All standards applicable to this service fully attained with some standards exceeded.

Residents have the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) made available to them. During admission and thereafter opportunities are provided to discuss the Code, consent, and availability of advocacy services.

Services are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

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

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

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

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

A complaints register is maintained with complaints resolved promptly and effectively. There have been no complaints investigated by external agencies since the previous audit.

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.

Oceania Healthcare Limited is the governing body responsible for the services provided at Heretaunga Home and Village. A mission, vision and values statements reflected a person/family-centred approach to residents. Information packs provided to residents and their families on admission and displayed within the facility include this information. Staff are also provided with this information at orientation and ongoing training.

Quality and risk management systems are well embedded and support the provision of clinical care and quality improvement. Policies were current and reflected good practice. Reports to the Oceania support office provide monthly monitoring of service delivery.

The service is managed by a business and care manager who started in the position in January 2020. The business and care manager is supported by the clinical manager, the regional clinical quality manager, the regional operations manager and support office.

Quality, staff, registered nurse, restraint, health and safety, infection control and residents' meetings are held on a regular basis.

Actual and potential risks, including health and safety risks, are identified and mitigated.

Policies and procedures on human resources management are implemented. Staff have the required qualifications. An in-service education programme is provided, and staff performance is monitored.

A documented rationale for determining staffing levels and skill mix is in place. The two managers are rostered on call after hours.

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

Continuum of service delivery

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

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

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

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. 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 registered nurses and care staff, all of whom have been assessed as competent to do so.

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

Safe and appropriate environment

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

Standards applicable to this service fully attained.

A building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

There is a mix of rooms with individual full ensuites and those with a wash hand basin and a toilet. Adequate numbers of additional bathrooms and toilets are available. Each area has a lounge and dining area with alcoves provided throughout the facility. The areas have individual garden areas with shade and sitting.

An appropriate call bell system is available, and residents reported timely responses to call bells. Security and emergency systems are in place. Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held six monthly.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. Some laundry is undertaken on site with linen laundered at another facility within the Oceania group. Cleaning and laundry processes are evaluated for effectiveness.

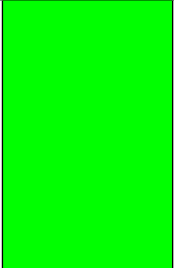
Restraint minimisation and safe practice

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 service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraints and enablers at the time of audit. Restraint processes in place to meet the standards.

Infection prevention and control

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

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	1	100	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](#).

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

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

		<p>was activated or a Protection of Personal and Property Rights (PPPR) in place, plus a specialists authorisation for placement.</p> <p>Staff were observed to gain consent for day-to-day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were available at reception. Family members/whānau and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family, though this has been difficult due to covid restrictions. Community outings, visits, shopping trips, activities, and entertainment are at present not occurring at Heretaunga. Van outings occur to enable residents to go out for a scenic drive.</p> <p>The facility at present has restricted visiting hours due to Covid-19 restrictions and encourages visits from residents' families and friends during allocated appointment times. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and complaints information and forms are available at the main entrances.</p> <p>Thirteen complaints have been received in the last year and these have been entered into the complaints register. Complaint documentation was reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible. Significant complaints are escalated to the clinical governance group for review, delegation of any investigation and provision of support and advice.</p> <p>The business and care manager (BCM) is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required.</p>

		There have been no complaint investigations by external agencies since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family/whānau of residents when interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in the reception area together with information on advocacy services, how to make a complaint and feedback forms.
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	<p>Residents and families/whānau of residents confirmed that services at Heretaunga are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families and the general practitioner (GP) or nurse practitioner (NP). All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. This has stopped recently due to Covid-19 restrictions; however, independence is encouraged within the facility. Each resident's care plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Residents' records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
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	There were no residents at the time of audit who identified as Māori. One staff member identifies as Māori. Interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and family members/whānau of residents confirmed that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes, religious practices and attention to preferences around activities of daily living. The resident satisfaction survey includes evaluation of how well residents' cultural needs are met, and this supported those individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Heretaunga encourages and promotes good practice through a stable workforce, who have worked at Heretaunga for a long time, a supportive management team, evidence-based policies and regular ongoing in-service education sessions. Input from external specialist services and allied health professionals is provided, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, community dietitians, services for older people, psycho-geriatrician and older persons mental health team. Heretaunga has their own NP who is available to manage the care of residents and offer advice to the registered nurses (RNs) if needed.</p> <p>A multidisciplinary review group, that includes a range of expertise from the HVDHB is held every month at Heretaunga's sister site. Any residents of concern can be reviewed at that meeting. The NP has direct access to NPs at HVDHB medical and older persons mental health services. Onsite visits or phone consultations by the NPs often enable concerns to be addressed at Heretaunga rather than requiring the resident to be admitted to HVDHB. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and to attend conferences</p>

		<p>that focus on improving the quality of care provided by Heretaunga. RNs reported they are aided to undertake post graduate training, including training to be a NP and access their own professional networks, such as on-line forums, to support contemporary good practice. Healthcare assistants at Heretaunga are participating in the fundamentals of palliative care training offered by the hospice.</p> <p>Other examples of good practice observed during the audit included a commitment to ongoing improvement in the access to prompt medical care, by the employment of a nurse practitioner dedicated to the organisation's care facilities in the area.</p> <p>Evidence was sighted of a reduction in pressure injuries over the past 12 months and a commitment to pressure injury prevention and improved wound care management. This has been awarded a continuous improvement rating.</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>Residents and family members/whānau of residents stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the GP and the infection control nurse from the HVDHB when required. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The Oceania Healthcare Limited vision, values, mission statement and philosophy are displayed. The organisation has systems in place recording the scope, direction and goals of the organisation. A Heretaunga operational and business brief includes an executive summary, appearance status, regional overview and strengths and weaknesses.</p> <p>Monthly reports are provided to the support office. Reports include quality and risk management issues, occupancy numbers, human resource issues, complaints, abuse, quality improvements, policies, education, issues, internal audit outcomes and clinical indicators.</p> <p>The facility is managed by an experienced BCM who has been in the position since January 2020. Prior to this appointment they were situated offshore completing a masters degree in business administration, and managing health facilities. The BCM is supported by the clinical manager (CM) who is responsible for overseeing the clinical service. The CM is an experienced clinical manager</p>

		<p>who has been in this role since March 2020 and prior to that was the clinical manager in another aged care facility.</p> <p>Heretaunga has a contract with the DHB for aged related residential care services. All residents were under this contract (19 hospital, 20 rest home and 19 dementia level). A short term residential care (respite) contract is also in place. The BCM advised Heretaunga has a waiting list. There is one private resident in a care suite (grand parented) under an Occupational Rights Agreement who is not assessed as hospital or rest home level and the room is not currently certified.</p> <p>All beds (rest home, hospital and care suites under an Occupational Rights Agreement) apart from the dementia beds, have been approved as dual purpose.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>If the BCM is absent, the CM will fill the role with support from the regional operations and clinical managers. During the absence of the CM, the senior RN will cover the clinical service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The Oceania documented quality improvement policy defines quality, quality assurance and quality improvement. The facility's quality improvement is defined in the quality plan, the policies and procedures and Oceania's model of care and quality and risk framework which guides the quality programme.</p> <p>Service delivery is monitored through robust reporting systems utilising a number of clinical indicators including but not limited to infections, complaints, falls, medication errors, weight loss, wounds, food safety and implementation of the internal audit programme. The electronic clinical records collection and reporting system automatically generates quality data from the clinical records. The internal audit programme is implemented as scheduled and documentation reviewed evidenced quality improvement data is managed well. Data is being collected and collated with analysis that identifies any trends. Corrective action plans from quality activities are developed, implemented, reviewed and closed out. Month by month graphs are generated as well as benchmarking with other like facilities within the group.</p> <p>All aspects of quality improvement, risk management and clinical indicators are discussed at the various meetings held. Copies of meeting minutes are available for staff to review and sign to confirm that they have read these. Staff confirmed they are kept well informed of quality</p>

		<p>improvements and any subsequent changes to procedures and practice through meetings. Residents and families are notified of changes and events at the residents' meetings. Residents and families interviewed confirmed this.</p> <p>Satisfaction surveys for residents and families are completed as part of the annual internal audit programme. Surveys reviewed evidenced high satisfaction/satisfaction with the services provided.</p> <p>Policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. Policies are reviewed nationally with comments sought from staff, reviewed by the clinical governance group and signed off. The CM reported new or revised policies are discussed at the various meetings and as part of relevant in-service education. Minutes of meetings confirmed this. Staff are advised new/updated policies are available electronically with a hard copy provided in the staff room. Staff confirmed they are made aware of new and updated policies.</p> <p>The organisation has a risk management programme in place. A health and safety plan and objectives plus policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff confirmed an awareness of health and safety processes and their responsibilities to report hazards, accidents and incidents promptly. Accidents, incidents and corrective actions are discussed at staff, health and safety and quality meetings.</p> <p>The health and safety representative demonstrated good knowledge of their role and have completed the health and safety training. Hazard identification forms are completed when a hazard is identified, addressed and risks minimised. There is a national risk register plus a site-specific hazard/risk register that is reviewed at each health and safety meeting and updated at least annually or when a new hazard is identified. Review of the registers and meeting minutes confirmed this.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>An incident/accident and sentinel policy is in place. A facility register records all events. Adverse, unplanned or untoward events are documented electronically by the RN on shift. All care issues are received by the CM who is responsible for investigating low and moderate adverse events and discusses these with the nurse practitioner monthly. Sentinel events, including absconding and sudden death, are received by the regional clinical manager and escalated to the group services/clinical director. All incident/accidents are investigated with corrective actions developed and implemented and evidenced close out. Documentation reviewed and interviews of staff indicated adverse events are managed well.</p> <p>Residents' files evidenced communication with families following adverse events involving the</p>

		<p>resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Policies and procedures comply with essential notification reporting. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The CM reported there have been 11 Section 31 notifications to HealthCERT, all related to RN shortages. The change of BCM and CM since the previous audit has been notified to HealthCERT.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>A staffing policy is in place that meets the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions, with accountabilities, responsibilities and reporting lines clearly identified.</p> <p>Staff files are managed well and demonstrated that recruitment processes for all staff include an application, CV, reference checks, police vetting, a current work visa where relevant, identification verification, a position specific job description, drug screening and a signed employment agreement.</p> <p>A system is in place to ensure that annual practising certificates are current. Current certificates were evidenced for all staff and contractors who required them.</p> <p>An orientation/induction programme is available that is position specific and covers the essential components of the services provided. Health care assistants (HCAs) are buddied with an experienced HCA and RNs with RNs for at least three shifts. New staff have a month to complete the induction including a number of competency assessments.</p> <p>The ongoing education programme is developed by the Oceania support office education and research team who develop the role specific mandatory annual education and training module/schedule, that includes topics relevant to all services and levels of care provided. Training is currently provided for HCAs through study days repeated throughout the year. Registered nurses attend a study day per year including palliative care, wound care infection control and other subjects provided by the DHB. Online learning is also undertaken on a variety of subjects. There are electronic systems and processes in place to ensure that all staff complete their required mandatory training modules and competencies. The CM is responsible for alerting staff as to what training they need to complete and when training is overdue. Staff have current first aid certificates.</p> <p>Two of the four RNs have completed interRAI assessment training and competencies. Care staff complete annual competencies or demonstrate awareness on specific tasks, for example, medication management, restraint, moving and handling, and health and safety awareness.</p>

		<p>Education session attendance records evidenced that ongoing education is provided relevant to the services delivered. Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of relevant education and training hours per annum. Health care assistants are encouraged to complete Careerforce training. Currently three have attained level 4 and seven have attained level 3. Health care assistants working in the dementia unit have completed or are completing the dementia specific units. Support office provides an assessor.</p> <p>An annual performance appraisal schedule is in place. All staff files evidenced staff have completed a current performance appraisal.</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>The organisation's staffing policy provides guidelines to ensure staffing levels are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract. Staffing levels are determined by acuity, the layout of the facility and occupancy to ensure there is appropriate skill mix of staff available. Staffing is adjusted as residents' acuity changes. When required, additional staff are rostered on duty.</p> <p>There are sufficient RNs and HCAs available to safely maintain the rosters for the provision of care. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy. The facility has rosters for the rest home/hospital, the dementia unit and the care suites. The BCM and CM work fulltime Monday to Friday and are on call after hours.</p> <p>There were 39 hospital/rest home residents on the first day of audit (including the care suites). On the morning shift there was one RN and six HCAs. On the afternoon shift there was an RN and five HCAs. On the night shift an RN covers all areas with a health care assistant in the rest home/hospital areas and one in the care suite area.</p> <p>There were 19 residents in the dementia unit with three HCAs on the morning shift, two on the afternoon and night shift.</p> <p>Of the four RNs, one has completed the Competency Assessment Programme (CAP) course and started in April 2020. Another is a relatively new graduate who started nine months ago. The senior RN is very experienced in aged care and the fourth RN is experienced in aged care and is on loan from another local facility within the group. The BCM reported two RNs have left employment in the last six weeks. An experienced RN who is interRAI trained was starting employment following the audit and the BCM stated they have advertisements currently seeking other RNs and that it is a difficult situation currently with very little responses. The BCM stated they would use agency RNs, however, there are none currently available. The CM works on the floor when and if a shift is without an RN. The HCA workforce is stable with at least 40% of staff having been employed for more than five years and some over 20 years.</p>

		<p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Residents and families stated they felt there were sufficient staff on each shift to meet the needs of residents. Staff confirmed that they have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP, NP, and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held off site by an external company and are readily retrievable using a cataloguing electronic system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter Heretaunga when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the business and care manager (BCM) or the clinical manager (CM). They are also provided with written information about the service and the admission process.</p> <p>Residents requiring admission to the secure unit, require a specialist's authorization of placement, and an activated EPOA or PPPR in place.</p> <p>Heretaunga has a waiting list of residents requesting admission to Heretaunga. When a vacancy occurs, the CM visits the resident to ensure the resident is suitable for placement. If suitable the service liaises with the family/whānau and the NASC to organise the admission</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>appropriate. The service uses an electronically generated report from the resident's file and the HVDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. The CM, NP and/or GP liaise over any transfers to an acute facility. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</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 was current and identified 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. The June 2021 check was not undertaken till September 2021 due to Covid restrictions at the time.</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 included 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 were two residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>Medication errors are reported to the RN and CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive</p>

		<p>analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Heretaunga.</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>	FA	<p>The food service is provided on site by a chef and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in October 2021. Recommendations made at that time have been implemented.</p> <p>A food control audit was undertaken in May 2021. Three areas requiring corrective action were identified and these have been addressed and signed off in June 2021</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and in resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p> <p>Residents in the dementia secure unit have access to food at any time.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Heretaunga are initially assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require.</p> <p>In all files reviewed, initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments were completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation, and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents had current interRAI assessments completed by two trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>Behaviour management plans were sighted in the files of residents in the secure unit. These includes triggers to behaviours and the strategies that are effective in de-escalating these behaviours.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations, and interviews verified that the care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the 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>FA</p>	<p>The activities programme is provided by a diversional therapist (DT) and an activities assistant. An interim activities coordinator has been employed and commences work the week after the audit, for 12 months.</p> <p>A social assessment and history is 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 resident's activity needs are evaluated regularly and as part of the formal care plan review every six months. The DT writes a summary in the resident's progress notes once a month.</p> <p>The DT is responsible for the planned monthly activities programme for the rest home/hospital residents and stated the assistant is responsible for the dementia residents programme with overview from the DT. A copy of the programme is given to each resident as well as displayed throughout the facility. The programmes sighted match 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. The DT stated the dementia residents join with the other rest home and hospital residents, especially when entertainers visit and going out on walks.</p> <p>The activities programme is discussed at the residents' meetings held every two months and minutes indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p> <p>Residents' files reviewed in the dementia secure unit have a 24-hour activity plan in place that addressed the residents' 24 hour needs and included previous lifestyle patterns.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' 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 service responds by initiating changes to the plan of care. Short-term care plans were consistently reviewed for infections, pain, weight loss, 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. Residents and families/whānau interviewed provided examples of involvement in</p>

		evaluation of progress and any resulting changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP/NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the NP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed as necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Domestic, kitchen and care staff have access to chemical training and management of chemicals. Material safety data sheets (MSDS) were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Chemicals were correctly labelled and stored securely.</p> <p>There is provision and availability of a significant amount of personal protective clothing and equipment. Staff were observed using these.</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>	FA	<p>A building warrant of fitness was displayed at the front entrance that expires on the 17 August 2022. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose.</p> <p>Residents and families confirmed they can move freely around the facility and that the accommodation meets their or their relative's needs. Passageways are wide and there is room for residents to pass comfortably in all areas. The facility internally is flat apart from one small change of level that is gentle and has handrails on either side of the passageway.</p> <p>There is a proactive and reactive maintenance programme, and the buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by the maintenance person who demonstrated good knowledge. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. Hot water temperatures at resident outlets are maintained</p>

		<p>within the recommended range.</p> <p>There are external areas available that are appropriate to the resident groups and setting. Large external courtyards with seating, shade, colourful gardens and lawns are available for residents to frequent in all areas. Gardens and lawns are maintained to a high standard by a contracted landscaping firm. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. The external area for the dementia unit residents is flat, provides good space to walk and is securely fenced.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. The care suites have full suites, one rest home/hospital room has a full ensuite and all other rooms have a toilet and wash hand basin including the dementia unit beds. Bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. Separate bathrooms for staff and visitors are available.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Bedrooms are spacious and allow residents and staff to safely move around in. Care suites have one or two bedrooms. Equipment was sighted in the rooms with sufficient space for both the equipment and at least two staff and the resident. The residents' rooms are personalised with their own furnishings, photos and other personal possessions. Residents and families are encouraged to make the room their own.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are numerous areas for residents to frequent. Good access is provided to the lounges and the dining room areas with residents observed moving freely. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas. Care suites have their own lounges and dining area.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Cleaning and laundry policies and procedures are documented and guide services at Heretaunga. The facility is cleaned to a high standard. There are processes in place for collection, transportation and delivery of linen and residents' personal clothing. Linen and large items are laundered off site at another facility nearby within the group. Personal and small items are laundered on site.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and visits from the chemical company representative. Reports from the chemical company representative and completed audits for laundry and cleaning were reviewed. A cleaner described the management of cleaning processes including the use of personal protective equipment.</p> <p>There are safe and secure storage areas and staff have appropriate and adequate access to these areas, as required. Chemicals were labelled and stored safely within these areas, with a closed system in place. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility.</p> <p>Residents and families were complementary of the cleaning service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>A letter from the New Zealand Fire Service letter dated 16 October 2003 approving the fire evacuation scheme was sighted. The last drill was undertaken on the 4 August 2021. Emergency and security management education is provided at orientation and at the in-service education programme.</p> <p>Documented systems are in place for essential, emergency and security services. Policy and procedures document service provider/contractor identification requirements along with policy/procedures for visitor identification.</p> <p>Information in relation to emergency and security situations was readily available/displayed for staff and residents. Emergency equipment is accessible, current and stored appropriately.</p> <p>The service has a call bell system in place that is used by the residents, families and staff members to summon assistance. All residents have access to a call bell. Call bells are checked monthly by the maintenance person. Residents confirmed they have a call bell and staff respond to it in a timely manner.</p> <p>The service has documented processes for essential, emergency and security services. There is at least one designated staff member on each shift with appropriate first aid training. Staff records sampled evidenced current training regarding fire, emergency and security systems.</p> <p>Information in relation to emergency and security situations was displayed and available for staff and residents with evidence of emergency lighting, torches, gas and BBQ for cooking and extra</p>

		food supplies. Emergency water is maintained in two tanks and 20 litre containers. External doors are locked in the late afternoon and sensor lights are situated externally around the facility.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The facility is heated by a combination of under floor heating, heat pumps and electric wall heaters. Procedures are in place to ensure the service is responsive to resident feedback regarding heating and ventilation in the facility. Residents and families confirmed the facility was maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff, and visitors through the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the CM. The infection control programme and manual are reviewed annually, and were last reviewed on the 5 January 2021.</p> <p>The senior RN with input from the CM is the designated infection control nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the regional clinical manager electronically, and tabled at the monthly infection control meetings and various other meetings. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The infection control nurse reported new national infection control meetings have started and all infection control nurses are invited to attend. Minutes of the first two meetings held were reviewed.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Restrictions on visiting was in place at the time of audit due to Covid-19 restrictions. All visiting is rostered, and all visitors are temperature scanned on entry. Staff interviewed understood all related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical,</p>	FA	<p>The infection control nurse (ICN) is an experienced RN who has been in the role for 12 months. They have appropriate skills, knowledge, and qualifications for the position. The ICN has undertaken infection prevention and control training online provided by the MoH on the 4 July 2021 and with the DHB on the 6 November 2020. The ICN has attended relevant study days, as</p>

<p>and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>evidenced in training records sighted. Well-established local networks with the GP and infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The ICN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICN and CM confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICN. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when there was a recent outbreak of respiratory syncytial virus (RSV).</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. The ICN stated an education session was provided to residents relating to respiratory infections and included a power point presentation.</p> <p>Ongoing training is evidenced to have occurred in the use of Personal Protective Equipment (PPE) and Covid pandemic planning.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<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 skin infections. 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 ICN and CM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via infection control, 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.</p> <p>A good supply of personal protective equipment is available. Heretaunga has processes in place to manage the risks imposed by Covid-19.</p> <p>A recent outbreak of respiratory syncytial virus (RSV) involved one resident being positive and other residents with symptoms. Isolation protocols were implemented, and four residents were provided with a course of antibiotics. The Public Health Unit was notified, and advice and support were provided.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint coordinator who is the CM stated Heretaunga is committed to becoming a restraint free environment. Three residents were using restraint and three residents were using an enabler during the audit. Equipment used includes sensor mats, high-low beds and landing mats.</p> <p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded and implemented.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, as confirmed at staff and management interviews.</p> <p>Staff interviews and staff records evidenced restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation ongoing training is provided. Restraint training is included in the staff mandatory study days and staff competencies were current. Restraint meetings are held two monthly and evidenced discussion on all activities concerning restraint use.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Restraint use is overseen by the restraint coordinator/CM and the responsibility for this position is defined in the position description.</p> <p>Restraints are authorised following a comprehensive assessment of the resident. The approval includes consultation with other members of the multidisciplinary team and the resident's family. The restraint consent forms evidenced consent for restraint is obtained from the GP, restraint coordinator and the resident and /or a family member. All documentation including monitoring is included in the electronic resident information system.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Restraint assessments were completed and identified restraint related risks, underlying causes for behaviour that requires restraint, existing advance directives, history of restraint use, history of abuse and or trauma the resident may have experienced, culturally safe practices, identification of desired outcomes and possible alternatives to restraint. There was evidence that all enabler and restraint use was initiated following completion of appropriate assessments.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint coordinator stated that restraints are used as a last resort after alternative interventions have been explored. The restraint register is current and meets the standard. Monitoring of restraint is recorded electronically. Staff have current restraint competency assessments.</p> <p>Staff are aware of advocacy services and that support is available. The contact details for this service are documented and the service can be accessed when needed to inform residents and their families.</p> <p>Documentation in the residents' files relating to risk around restraint is individualised and evidenced good detail.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint coordinator confirmed evaluations of the restraints are completed at three-monthly intervals. Evaluation and review of restraints meet the standard. The restraint coordinator and RNs confirmed communication with families is held regarding restraint and enabler use and discussions are held around reducing or minimising any restraint. Input from the NP and GP is included.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The evaluation of restraint occurs through restraint event reporting by the facility to the support office by measuring relevant clinical key performance indicators. Each individual episode of restraint is evaluated. Quality review of restraint is managed through the internal audit programme and the restraint meetings and other meetings as appropriate. Review of documentation and interview of the restraint coordinator confirmed this. A national quality review of restraint is undertaken by the national restraint committee, annually.</p> <p>The residents and their families are involved in the evaluation of the restraints' effectiveness and continuity.</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.

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>A quality initiative was developed and implemented by the clinical team at Heretaunga following increasing numbers of residents presenting with pressure injuries. The team were aware that when a person reaches the final days of life, skin begins to change and despite active treatment and ongoing assessment and review, the skin breaks down. Pain assessment and minimising the impact of this process became a focus for all residents.</p> <p>During the last 18 months, the clinical team has worked together during each incidence; assessing, reviewing, adjusting care, assessing, and reviewing again. Debriefing occurred during monthly case reviews with the NP, the HVDHB and the wound specialist nurse who was also available for any on-line referrals.</p> <p>Treatment included using Menalind foam to protect the pH balance of skin, Cavillon was applied to protect surrounding skin and Hydrosorb gel was added when healing appeared to slow down during evaluation.</p> <p>Metranidazole powder was added when indicated, following discussions</p>	<p>In 2020 eight residents developed pressure injuries and the clinical team recognised that they were not healing with the current treatment used. Improved management of pressure injuries was facilitated which resulted in healing of existing wounds and the prevention of pressure injuries occurring.</p>

		<p>with the GP and wound specialist nurse. In May 2020 Prontasan wound soaks were introduced with each dressing change to remove existing biofilm and prepare the wound bed for healing.</p> <p>Pressure relieving aids, mattresses, chair cushions, heel protectors, high protein drinks were provided to aid wound healing.</p> <p>Clinical staff were provided with extra training and pressure injury posters were placed in offices around the facility to support staff with early recognition of pressure injury.</p> <p>As a result of the measures put in place, pressures injuries have decreased from eight in 2020 down to two in the first six months of 2021 and currently there are no residents with pressure injuries at Heretaunga.</p>	
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End of the report.