

Heritage Lifecare Limited - Rosewood Rest Home & Hospital

Introduction

This report records the results of a Provisional 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: Rosewood Rest Home & Hospital

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

Dates of audit: Start date: 24 February 2022 End date: 25 February 2022

Proposed changes to current services (if any): This provisional audit of Rosewood Rest Home and Hospital was required as Heritage Lifecare Limited is currently in the process of purchasing the facility.

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.

General overview of the audit

Rosewood rest home and hospital provides rest home dementia care, hospital level care and hospital specialised services for up to 66 residents. The service is privately owned and managed by a facility manager and an off-site general manager. Heritage Lifecare Limited (HLL), a key provider of aged care services in New Zealand, is in the process of purchasing Rosewood. Families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contracts with the Canterbury District Health Board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, a representative of the prospective provider and a general practitioner.

The audit identified four areas requiring improvement. These relate to corrective action follow-up, food temperatures, 24 hour activity plans and restraint documentation.

Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of community services and specialist health care providers to support best practice and meet resident's needs.

The service has a complaints policy and associated procedures which comply with Right 10 of the Code.

Organisational management

A business plan and a quality and risk management plan include the scope, direction, goals, values and mission statement of the organisation. Monitoring reports about the services are provided to the director on a regular basis. An experienced and suitably qualified person manages the facility and is supported by an off-site general manager.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from family members. Adverse events are documented with remedial actions implemented as relevant. Actual and potential risks, including hazards and health and safety risks, are identified and mitigated. Policies and procedures support service delivery, are current and are reviewed regularly.

Processes for the appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery. Regular individual staff performance reviews are occurring. Staffing levels and skill mix meet the changing needs of residents and address the reducing availability of registered nurses whilst meeting contractual requirements.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Any prospective resident is required to have a needs assessment prior to entry. Access to the facility is appropriate and efficiently managed with relevant information provided to the prospective residents and their families.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans and activity plans are individualised, based on a comprehensive range of information. Appropriate planning and interventions occur for any new problems that arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis.

Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed in accordance with a registered food control plan.

Safe and appropriate environment

Waste and hazardous substances are well managed. Protective equipment and clothing is available and are being used by staff.

The different units within the facility meet the respective needs of the residents. A current building warrant of fitness is on public display and the buildings are well maintained. Electrical equipment is tested as required and ongoing maintenance and safety checks are occurring. Records of these are current. Communal and individual spaces are light, well ventilated and the air temperatures are monitored. External areas accessible, safe and provide shade and seating. These are in the process of being redesigned.

Chemicals, soiled linen and equipment are safely stored. The facility is clean and tidy. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Security is maintained.

Restraint minimisation and safe practice

The organisation implements policies and procedures that support the minimisation of restraint. A lap belt is being used with one resident and is the only current approved restraint. There are comprehensive assessment and approval processes in place and regular reviews of restraint use are occurring. Staff demonstrated a sound knowledge and understanding of the restraint process and are aware of the voluntary nature of any use of an enabler.

Infection prevention and control

An infection prevention and control programme, which aims to prevent and manage infections, is reviewed annually. The programme is led by a newly trained infection control coordinator with support from the facility manager who has experience in the field. Specialist infection prevention and control advice is able to be accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and procedures. Regular education on infection prevention and control is available for staff.

Aged care specific infection surveillance is undertaken, 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	46	0	3	1	0	0
Criteria	0	97	0	3	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Rosewood Rest Home and Hospital has policies, procedures 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 in the orientation process for all staff employed and is provided in ongoing training every year. This was verified in staff training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Resident files reviewed showed that informed consent has been gained using the organisation's standard consent form. Additional consents were observed for flu and Covid-19 vaccines.

		Residents have enduring power of attorney (EPOA), activation documentation, and signed admission agreements on file. The registered nurse stated that advance directives would be acted on when available.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, family members and residents are given a copy of the Code, which includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were displayed and available in the facility. Family members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The RN said there were no examples of advocacy services being required.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits to local cafes, shopping trips, walks and activities. The diversional therapist explained that visiting entertainers and those holding church services also take time to talk with residents when they visit, which was observed during the audit. The facility currently requires booking a booking system for visiting due to Covid-19 restrictions but family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints and concerns policy, procedure and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided on admission and family members interviewed were aware of how to raise a concern/complaint if required. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. An electronic complaint register reviewed showed that only one complaint has been received over the past year and that actions taken are documented and completed within the expected timeframes. This

		<p>complaint was concurrently raised with the Health and Disability Commission (HDC). Verbal reports and copies of documentation sighted demonstrated all interventions requested by both the District Health Board and the HDC have been followed up and completed. The service provider is currently waiting on the latest response from the HDC. There have been no other complaints received from external sources since the previous audit.</p>
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	<p>Residents were not able to express their familiarity with the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service); however, family members interviewed confirmed these had been discussed with them when their relative entered the service and that they had received information about them.</p> <p>The Code in both English and te reo Māori was sighted on display in the three units and at reception. Information on advocacy services, how to make a complaint and feedback forms were available in each of the nurses' stations and in the reception area at the front of the building.</p> <p>The prospective provider knows and understands the consumer rights that must adhere to.</p>
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>Families confirmed that the residents receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Throughout the audit, staff were observed to maintain residents' privacy, and where relevant to give residents choices. All residents have a private room and although there are two double rooms, both currently only have one resident.</p> <p>Residents are assisted to maintain their independence. Care plans described each person's level of independence according to their abilities and staff were observed assisting residents and prompting them in the next step in a process.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified,</p>

		<p>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 was confirmed to occur during orientation and annually. Family members interviewed expressed they had not observed any type of abuse, or evidence of disrespect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service 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. There is a specific room designated as a whānau room for use for meetings and other activities. The Māori Model of Care 'Te Whare Tapa Wha' guides staff in holistic care for Māori residents. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Staff acknowledge and respect their individual cultural needs as observed during audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Family members verified that they were consulted on the residents' individual culture, values and beliefs during the admission process and that the staff respect these. Residents' preferences, special needs and associated interventions were included in the care plans reviewed. Church services are held within the facility each month.</p> <p>The resident/family satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members who were interviewed stated that residents were free from any type of discrimination, harassment or exploitation. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Staff sign a Code of Conduct when they commence employment. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect</p>

		any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the practice of commencing each new resident on a short-term care plan (STCP) on admission which staff added to over the next three weeks, alongside input from family which gave a complete picture of the resident which was invaluable in gathering information on those residents that are nonverbal and often poor historians. Once this information was used to inform the interRAI assessment and long-term care plan (LTCP) the STCP was signed off.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Family members stated they were kept well informed about any changes to their relative's status. They also informed they are advised in a timely manner about any incidents or accidents and the outcomes of regular and any urgent medical reviews. This was supported by progress notes of residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Registered staff know how to access interpreter services, although reported this has not been required due to multicultural staff and family involvement. Staff informed that picture charts have been used to assist with communication and translation apps. Resident doors had signage for those that were hard of hearing.</p>

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The strategic and business plan, which is reviewed annually, outlines the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A template used for weekly reports to the general manager was viewed. The general manager meets with the director in person most weeks and discusses these reports. Both the general manager and the director were at the audit and informed they receive adequate information to monitor performance.</p> <p>The service is managed by a facility manager who holds relevant qualifications, has more than 30 years of management experience and has been in the role for over two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager is also a registered nurse with a current annual practising certificate. They confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through participation in DHB forums, attendance at Aged Care Association training days, maintaining networking relationships with other key players and reading relevant research articles.</p> <p>The service holds contracts with the Canterbury District Health Board under the Age-Related Residential Care (ARRC) Services Agreement and the Aged Residential Hospital Specialised Services Agreement to provide support for aged care residents requiring respite care, medical conditions, palliative care, specialist hospital care and dementia rest home care. Fifteen of 20 available beds in the hospital services unit were occupied. Two other hospital level care residents were in the public hospital during the audit. Twenty-four residents were in the 26 bed rest home dementia service. Two double rooms are registered to accommodate two people in each; however, they are only used as single rooms. Twenty of the 20 hospital specialised services beds were occupied at the start of the audit.</p> <p>Heritage Lifecare Limited, as the prospective provider, is well prepared for taking on Rosewood rest home and hospital as it is already responsible for more than 39 care homes nationwide. The governance structure and operational systems of HLL will take over from the</p>

		<p>current private ownership. A regional manager for the organisation was interviewed by telephone following the audit and confirmed HLL's familiarity with the ARRC services agreement, the Aged Residential Hospital Specialised Services Agreement and with consumer rights as described in the Code. Both the Ministry of Health and the Canterbury District Health Board as funder of the proposed purchase have been notified. It was confirmed that the purchase takes place as from Monday 11 April 2022. Rather than a formal transition plan, HLL has a team of people to orientate new managers and the organisation has arranged for a manager to spend time with the current facility manager, who will remain in this role (known within HLL as the care home manager). For several weeks, this person will go through HLL policies, procedures, processes and systems to bring the care home manager up to date. The local regional manager for HLL will be available to provide ongoing information and support as required.</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>When the facility manager is absent, a senior registered nurse who was previously in a care coordination role carries out all the required duties under delegated authority. Additional support is available from the facility administrator and from the general manager based in Whanganui. During absences of key clinical staff, the clinical management is overseen by the facility manager/registered nurse, who is also experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff confirmed that although there is a shortage of registered nurses, the current arrangements work well.</p> <p>Heritage Lifecare Limited already has systems in place that ensure there is adequate staff when rostered staff and managers are absent or staff changes occur. This includes use of staff from other HLL facilities or sharing staff from other facilities in the city.</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>	PA Low	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, internal and external audit activities, annual regular next-of-kin and staff surveys and the monitoring of clinical incidents including infections, falls, medication</p>

		<p>errors and restraint use for example. A quality consultant provides the organisation's policies and procedures and supports the organisation to implement the quality and risk system.</p> <p>Heritage Lifecare Limited currently has a well-established quality management system that meets the requirements of the standard. Rosewood rest home and hospital will transfer into this following the change of ownership.</p> <p>All staff meetings are held monthly and meeting minutes reviewed confirmed regular review and analysis of quality indicators is occurring. These are complemented by regular registered nurse meetings where clinical outcomes are reviewed. Related information is reported and discussed at both of these meetings and staff interviewed reported they are updated on any issues raised and any incident form they complete. The facility manager described how each staff person is allocated a specific roles or tasks according to their preferences and strengths, including within the quality and risk system.</p> <p>Corrective actions are raised and entered into an electronic log. Although there were reports of some corrective actions taken, there was minimal documentation to support the closure of these, especially those related to internal audit outcomes. A next of kin satisfaction survey is completed annually with the last being February 2021. The most recent survey showed the positives as being the accessibility of the facility, the timely manner in which the GP contacts family and high levels of satisfaction with staff skills and their knowledge about the preferences of individual residents. Areas for improvement related to meeting residents' cultural and spiritual needs, residents' personal hygiene and knowing exactly who to speak to about their family member. The staff survey identified the great support provided, the teamwork and the ability to approach senior team members, while pay rates and having sufficient suitable equipment were raised as concerns. Efforts have been made to address the shortcomings identified one year ago. Ideas and plans for quality improvement projects were discussed during the audit. Other than the need for the HDC complaint as described in 1.1.13 above still to be closed out, there are no legislative compliance issues that could affect the service when HLL take over Rosewood rest home and hospital.</p> <p>Policies reviewed cover all necessary aspects of the service and</p>
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		<p>contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Heritage Lifecare Limited has its own policy and procedure system, which Rosewood rest home and hospital will take over when the change of ownership occurs.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and hazard and development of mitigation strategies. Relevant documentation was sighted. The facility manager is also familiar with the Health and Safety at Work Act (2015) and implements requirements alongside a health and safety officer who has also completed relevant training.</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>	FA	<p>Staff document adverse and near miss events in the electronic accident/incident system. A sample of completed incidents documentation reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up. Adverse event data is collated, analysed and reported to registered nurse meetings including the facility manager, all staff meetings, the general manager and ultimately the director.</p> <p>The facility manager described essential notification reporting requirements, including for people absconding from any of the units. They advised that reports have been made to the Ministry of Health for a person with a fractured femur and several incidences of shortages of registered nurses since previous audit. No other notifications have been required. As noted in 1.1.13 under complaints management the DHB and the HDC office have been involved in a serious complaint.</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</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes a formal application process, referee checks, interviews, police vetting and validation of qualifications and practising</p>

		<p>certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. More recent employees interviewed reported that the orientation process prepared them well for their role. Human resource records reviewed show documentation of completed orientation. A performance review after a six-to-eight-week period is now undertaken with new staff.</p> <p>Staff education/training schedules for 2021 and 2022 were reviewed and include mandatory training requirements. The schedule showed internal and external opportunities are available and the facility manager described an increasing use of on-line and paper-based training packages. Examples of these were viewed. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. Two caregivers are undertaking diversional therapy training and have commenced dual roles of caregiving and diversional therapy. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Spreadsheets on staff education/training were reviewed. These are comprehensive and demonstrate staff are completing the required training and performance appraisals are occurring annually.</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>	FA	<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) as per contractual obligations and acuity of residents within the service. Heritage Lifecare Limited as the prospective provider also has a document that describes a process to manage staffing levels and skill mix and this will be used following the change of ownership.</p> <p>The facility manager and registered nurses adjust staffing levels to</p>

		<p>meet the changing needs of residents. Care staff reported there is adequate staff available to complete the work allocated to them. Those interviewed were approving of changes made to duty schedules to accommodate the lower number of registered nurses now available. They also informed there is good access to registered nurse advice and support at all times.</p> <p>The facility manager is on call 24 hours a day, seven days a week with additional support available from a senior registered nurse when necessary. Family members interviewed reported high skill levels of all staff and the open communication from the facility manager and registered nurses. Review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced, or shifts extended to cover any unplanned absence. The facility manager spoke openly about the difficulties in employing additional registered nurses despite extensive efforts to do so and expressed concerns going forward if this trend continues. During review of four weeks of roster it became evident that the facility manager is currently taking pragmatic approaches to ensure there is registered nurse cover 2/7. Long serving level four caregivers are being trained to take on additional roles such as medication administration, changes of shifts from night to daytime, the length of some shifts are being extended and short shifts implemented at key busy times of the day. All registered nurses have a first aid certificate as do all diversional therapy /activities staff, which ensures at least one staff member on every duty has a current first aid certificate.</p> <p>There are reportedly no immediate plans for HLL to change staffing levels within this service; however, the regional manager did inform during interview that HLL are currently implementing a project relating to accessing additional registered nurses which is expected to assist with the current shortage of registered nurses at this facility.</p>
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information entered into the Momentum electronic database. The service uses an

		<p>electronic system for resident files with staff having individual logins to maintain privacy.</p> <p>Archived records are held securely on-site upstairs and are readily retrievable.</p> <p>Residents' files are retained for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service</p> <p>and by specialist referral from specialist mental health services/older persons' mental health services for those going into rest home (dementia) and specialist hospital (psychogeriatric) services.</p> <p>Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the Needs Assessment Service Coordination services (NASC) and the GP for residents accessing respite care.</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 service agreements were on file. Service charges comply with contractual requirements.</p>
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	<p>Internal transfers may occur between dementia rest home and the hospital or the specialist hospital services at Rosewood. Such transfers may occur in the event a resident's overall health or behaviours change or deteriorate. This involves updating the interRAI and requesting a formal needs reassessment to be undertaken prior to the person transferring between services. A stay in an acute ward or in an aged care assessment and treatment unit may be required between such a transfer.</p>

		<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHBs '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/whānau. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed the staff at Rosewood had remained in constant contact with the acute service.</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. Medication rounds are currently undertaken by level four care givers with the RN checking controlled drugs. All medication competencies are current.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two nurses for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and entries were accurate.</p> <p>The record of temperatures for the medicine fridge and room reviewed were within the recommended range.</p> <p>Prescribing practices included a record of the date on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. Short term medicines were time-framed, and the person's allergy status noted. All GP reviews of</p>

		<p>residents' medicines were within three months, as required. There were no residents self-administering medications at the time of audit and the registered nurses stated that it would be inappropriate within this setting.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>	PA Low	<p>The food service is provided on site by a qualified cook and kitchen team, 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 within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Christchurch City Council and is current until 29 January 2023. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan in the kitchen but when food is transported to and served in the other units there are no records of temperature monitoring at point of service. The food services manager 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. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet residents' nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and satisfaction surveys. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a dignified manner.</p>

Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The service has a waiting list of residents wishing to enter the service. 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. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, cognition and behaviour and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process. Information from family members is especially sought in residents with lowered cognition. Family members interviewed confirmed their involvement in the assessment processes.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. 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 is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of

		care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified 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 GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and that a high level of care is provided, especially when some of the residents present with behaviours that challenge. Healthcare assistants 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.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low	<p>The activities programme is provided by two registered diversional therapists holding the national Certificate in Diversional Therapy, and an activities coordinator. Church services are provided by the community.</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 on engagement and as part of the formal six-monthly care plan review. Only two residents in the facility have a 24-hour activity plan, these files did not form part of the sample group reviewed, but on asking staff identified and presented examples from other resident files.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through satisfaction surveys. Residents were observed actively involved in entertainment on the day of audit.</p> <p>Activities for residents from the secure dementia unit are specific to the</p>

		needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes music and a walking/exercise group as well as group and individual activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, and as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the long-term plan of care. Examples of electronically recorded short-term care plans being consistently reviewed were viewed for infections, changes in behaviours and skin tears. Unresolved short-term problems are added to long-term care plans as necessary. Families/whānau interviewed provided examples of involvement in evaluation of progress.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to Acute Demand, Nurse Maude wound clinic and for physiotherapy assessment. The resident (regardless of their level of understanding or ability to recall) and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary and a hazard register is kept updated. An external

<p>harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>company is contracted to supply and manage all cleaning and laundry products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, a spill kit is available and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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 current building warrant of fitness with an expiry date of 21 June 2022 is publicly displayed in the reception area.</p> <p>Appropriate review systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Records of these are now digitalised and are up to date. Key external entrances and entry doors to the rest home, dementia care unit and the hospital specialist services units have digital locks in situ to ensure the safety of people with varying levels of dementia. Ongoing renovation of the older building where the rest home residents live has made the environment brighter and more stimulating. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. These are currently being redesigned to encourage residents to use outdoor courtyard areas more and to facilitate upkeep. Family members were very positive about the internal and external areas in the 2021 survey feedback.</p> <p>The regional manager from HLL confirmed during interview that it is their understanding that there are no immediate plans to make any environmental changes at the Rosewood rest home and hospital, although this may take place at a later date with plans to refurbish a number of HLL facilities.</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. All rooms have shared ensuites between two rooms except for six in the rest home where there is a shared toilet block with a toilet and two showers. Additional toilets for residents to use are in each unit. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation and although there are two double rooms in the rest home area that could accommodate two residents in each, these are only ever used for one person.</p> <p>Wherever possible, rooms are personalised with furnishings, photos and other personal items displayed. This is more difficult in the hospital specialist services area as items are often shifted, removed or even destroyed by other residents. Diversional therapists make efforts to maintain a homely environment as much as possible.</p> <p>There is room to store mobility aids, wheelchairs and two people's mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. The hospital specialist services unit has a combined dining and lounge area. Residents in each unit have areas they can access for privacy, if required and there is a library and new whānau room in the rest home unit. The hospital unit has two lounge areas for residents to choose between. Furniture is appropriate to the setting and residents' needs.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken in two separate laundries on site by the caregivers, mostly during the night shift. Arrangements are in place for laundry to be contracted out in the event of an outbreak. Care staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Family members interviewed reported the laundry seems to be managed well and their family member's clothes are returned in a timely manner. Staff informed that when relatives advise of any clothes having gone astray they make every effort to follow these up and are usually successful.</p> <p>There is a small designated cleaning team who have received appropriate training. One newer person is awaiting a time slot for this but demonstrated basic safety principals when interviewed. Chemicals are stored in a lockable room and are in appropriately labelled containers. All units in the facility were observed to be clean on the two days of audit.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. Not all corrective actions from the last audit had been followed up. (Refer corrective action in criterion 1.2.3.8.)</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. Records sighted confirmed fire safety equipment is monitored by an external company within the required timeframes. The current fire evacuation plan was approved by the New Zealand Fire Service on 7 November 2006. A trial evacuation takes place at least six-monthly, with the most recent being the day before the audit. Trials occur in the different units on different days. Records show there has been frequent trial evacuations, which the manager informed had been undertaken to ensure all registered nurses and key staff were familiar with procedures should the manager be absent. The new staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p>

		<p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs were sighted and are stored in each unit. Additional stocks, including food, were viewed in a storeroom near the front entrance. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and families reported staff respond to most call bells promptly.</p> <p>Appropriate security arrangements are in place. The outside perimeter is locked. Doors and windows are locked at a predetermined time and windows have security latches in situ. Surveillance cameras are in use in communal areas and notices advising of their use are on each external door.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light with opening external windows. There is underfloor heating that is supplemented by heat pumps. Air temperature checks are a component of the maintenance schedule. Areas were warm and well ventilated throughout the audit and the next of kin survey confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually (20 April 2021).</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, general manager and owner. All infection data is discussed at RN meetings to ensure treatment is effective.</p> <p>A QR code is available at the entry and a digital declaration form and</p>

		<p>temperature check is required of all visitors which includes showing vaccine passports. Mask wearing is mandatory. Rosewood is guided by the Ministry of Health updates for their pandemic response and has completed training required such as donning and doffing of personal protective equipment. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities and described their use of personal protective equipment to help prevent the spread of infection.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse has just been appointed to take on the role of infection control coordinator. Additional education to upskill the registered nurse has been organised. Meantime, the facility manager who has appropriate skills, knowledge, qualifications and experience for such a role is supporting the new appointee. The infection prevention and control team includes management and clinical nurse coordinators from each key area.</p> <p>Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the GP and the local public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator and the facility manager confirmed the availability of resources to support the programme and any outbreak of an infection.</p> <p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for three years and has completed appropriate training as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support</p>

		the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in April 2021 and included appropriate referencing. 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. Hand washing and sanitiser dispensers are readily available around the facility and in each bedroom. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education has been provided by suitably qualified registered nurses, external providers and online training. Content of the training is documented and evaluated to ensure it is relevant, current and understood. Education opportunities with the residents in this service are limited; therefore, staff are taking on the responsibility for ensuring residents maintain good practice in relation to infection prevention and control by assisting them with handwashing. On the day of audit staff were observed providing hand sanitiser to the residents before lunch.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal and the upper and lower respiratory tract. Records showed the IPC coordinator at the time has reviewed all reported infections. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any

		<p>trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year and comparisons against previous years and this is reported to the facility manager and owner. Data is benchmarked externally with other aged care providers.</p> <p>There have been no reported outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for restraint management and any enabler use in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, one resident was using a lap belt as a restraint. A second had also been using a lap belt but has since died. The restraint coordinator noted that the nature of the residents in the services at Rosewood rest home and hospital meant that enablers were unlikely to be used, including for the hospital level care residents. Staff interviewed were aware of the difference between an enabler and a restraint, should an enabler be approved for use.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff. Also, use of low beds, mattresses on the floor and sensor mats was evident during a tour of the facility.</p> <p>The regional manager from HLL confirmed during interview that there are other HLL facilities that provide dementia services and those under the hospital specialised services contract, therefore are well versed in respect of restraint minimisation and safe practice. A person from HLL is currently implementing a project reviewing restraint use, reviewing options and ensuring policies and procedures meet the standard the service provider's philosophy.</p>

Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	<p>The restraint approval group, made up of the facility manager, the restraint coordinator/registered nurse, other registered nurses and a senior caregiver are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, the resident's file and an interview with the restraint coordinator that there are clear lines of accountability, that the restraint in use has been approved, and the overall use of restraints is being monitored and analysed. A role description for the restraint coordinator is available.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on the person's file. Use of the restraint is part of the resident's plan of care.</p>
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	<p>Assessment for the use of the restraint is documented and includes all requirements of the Standard. The registered nurse/restraint coordinator had undertaken an initial assessment with input from the resident's family/whānau/EPOA. A general practitioner was involved in the final decision on the safety of the use of the restraint and this was recorded in the associated documentation. The assessment process identified the underlying cause, history of restraint use, alternatives and associated risks. It was evident in the completed restraint approval and assessment documentation of the resident that the safety and security of the resident were priorities and had been considered.</p>
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Moderate	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members. Low beds, sensor mats and thick mattresses on the floor are already in use and the restraint coordinator described how these have precluded the use of restraint in some instances. All processes in place ensure dignity and privacy are maintained and respected.</p> <p>Observations revealed that personal restraint is being used for one</p>

		<p>person at times; however, this person does not currently have relevant assessment and approval documentation to authorise its use.</p> <p>The expected frequency of monitoring of the restraint is noted on the approval form. Staff informed during interview that they are reminded of restraint monitoring requirements during handovers. Documented monitoring records reviewed for the person currently using a restraint does not meet the required two hourly monitoring timeframe.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. It contains sufficient information to provide an auditable record. The register was reviewed and included the resident currently using a restraint and evidence of three who have previously used one. One of these people has died. The other two had been reassessed and have not required use of a restraint since.</p> <p>Staff have received training in the organisation's restraint minimisation and safe practise policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraint is to be minimised and were aware of how to maintain safety whenever it is in use.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Review of the file of the resident using a restraint showed that its use has been reviewed by both the team and the general practitioner. It is evaluated at the same time as the care plan and interRAI reviews and family/whānau are involved. According to meeting minutes reviewed, use of restraint is discussed at the registered nurse meetings and the monthly staff meetings, as well as reviewed during the six-monthly restraint approval group meetings.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review	FA	Although only one person is currently using a restraint, three people

Services demonstrate the monitoring and quality review of their use of restraint.	were using one at the last six-monthly review. As noted above, the restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meeting reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. An internal audit on restraint use identified the need for some staff to update their training and this was carried out. Minutes sighted and interviews with the restraint coordinator and the facility manager confirmed that any restraint use now is a last resort and only after all options have been explored.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Various processes such as the analysis of clinical data and internal audits are used to review specific standards and requirements as part of the quality and risk management system. Areas identified as requiring improvement are being identified and examples of internal audits with question marks in them were viewed. Corrective actions are developed and documented within an electronic corrective action register. Reports of actions taken to address a range of issues of concern, or the areas requiring improvement, were provided. There was limited evidence to demonstrate that required corrective actions are being consistently followed up and closed out.	Documentation available does not show that corrective action plans to address areas requiring improvement are being consistently addressed and closed out.	Corrective action plans intended to address areas identified as requiring improvement are consistently documented, implemented and demonstrate the issues are resolved. 180 days

<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>Meals are produced in the kitchen and placed in serving dishes and temperatures monitored before being placed in insulated containers and taken by trolley to the other two kitchenettes where they are served to residents. Temperatures are recorded in the kitchen and were within the recommended range but on arrival at the point of service are not temperature checked.</p>	<p>Food temperatures are not being checked at point of service in the two units where food is delivered via a trolley/insulated box.</p>	<p>Temperatures will be taken and recorded at point of service.</p> <p>180 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>The facility provides a diverse range of activities that are suited to the abilities of the residents and includes normal events that are meaningful to the residents. There are monthly plans and special events are catered for. Social profiles and assessments were complete in the files reviewed and a tick chart was in place to record participation.</p> <p>Some details of activities and behaviour management were observed in the activities care plan, however, none of the residents' files reviewed evidenced a 24-hour activity plan.</p>	<p>None of the care plans reviewed showed a 24-hour activity plan describing how behaviour is best managed or activities best suited to the needs of the resident over the 24-hour period as required by the contract.</p>	<p>Residents will have an individual 24-hour activity programme that describes behaviour management and individualised activities reflecting former routines covering the 24-hour period.</p> <p>180 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p>	PA Moderate	<p>Throughout the audit, staff were observed to be applying personal restraint to ensure the safety of one of the residents. Further discussion revealed this is often required and that a range of tactics have been, and continue to be used, to stop the person from leaving the unit (hospital specialised</p>	<p>Personal restraint is being applied for a resident in the specialised hospital services unit without approval for its use.</p> <p>Records for a person who requires two hourly monitoring for use of a restraint are</p>	<p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration and its outcome.</p> <p>Also, documentation</p>

<ul style="list-style-type: none"> (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. 		<p>services). Staff understood they were able to do this to ensure the person's safety and had not seen it as restraint as it was intermittent. The need for the person to be monitored and formally assessed was discussed and until this occurs a corrective action has been raised.</p> <p>The person using a lap belt as a restraint is being managed in a safe manner. The requirement for two hourly monitoring is on the approval documentation and on the monitoring form and verbal reports indicate this is occurring. However, the monitoring records are not all being completed in a manner that demonstrates this is consistently occurring. This too has been raised for corrective action.</p>	incomplete.	includes observations and monitoring of any resident during use of a restraint. 60 days
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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 audit.

No data to display

End of the report.