Heritage Lifecare Limited - Palms Lifecare

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:	Heritage Lifecare Limited
Premises audited:	Palms Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 June 2017 End date: 23 June 2017

Proposed changes to current services (if any): The service plans to reconfigure 38 rest home rooms (41 beds) in the existing rest home building to dual purpose rooms. This reconfiguration would result in a total bed number of 123 comprising of 22 hospital, 21 rest home and 80 dual purpose beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 103

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Palms Lifecare provides rest home and hospital level of care for up to 123 residents and is operated by Heritage Healthcare Limited. At the time of audit there were 103 residents living at the facility. The service is located within a wider retirement living community.

This audit consisted of a certification audit and a partial provisional audit. The partial provisional audit was to assess the preparedness of the services to provide an increase in hospital level of care in the existing rest home building. The reconfiguration is planned to be staged with a gradual increase to hospital level of care as the rest home rooms become available. The audit verified there are appropriate processes, environment and staff levels to provide for the increased numbers of residents at hospital level of care. The service and the head office have documented systems to meet the needs of the increased number of residents at hospital level of care.

There were no improvements required from both the certification and partial provisional audits.

Consumer rights

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

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 interacted with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was 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 specialist health care providers to support best practice and meet residents' needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided by the Palms Lifecare management and the Heritage Lifecare Limited (HLL) is regular and effective. An experienced and suitably qualified team manage the facility. There is a documented transition plan for the reconfiguration of the service.

Since Heritage Lifecare Limited took over the operation of the service, Palms Lifecare has been in the process of implementing the HLL quantity and risk management systems, including their policies and procedures. 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 residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

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

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

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.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might 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. Residents verified 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.

Services are provided in two adjacent buildings. Both buildings provide a clean, safe, secure environment that is appropriate to rest home level and hospital level of care. There are no changes required to the building to reconfigure the bed usage. The rooms sighted for reconfiguration are appropriate for either rest home or hospital level care.

Residents, visitors and staff are protected from harm as a result of exposure to waste, infectious or hazardous substances generated during service delivery. Laundry and cleaning services are conducted onsite by employed staff. There are adequate numbers of toilets, showers, and bathing facilities in each building.

Documentation identifies that all processes are maintained to meet the requirements of the building warrant of fitness and emergency management systems.

Planned and reactive maintenance is documented. Systems are in place for essential, emergency and security services, including a disaster and emergency management plan. No changes are required to the emergency and evacuation scheme for the reconfiguration of bed usage. Residents reported a timely staff response to call bells. Security is maintained.

All residents have access to outdoor areas with shaded areas.

Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler was in use at the time of audit. The use of enablers is voluntary for the safety of residents in response to individual requests. There were no restraints in use. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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, 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	45	0	0	0	0	0
Criteria	0	93	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The facility has developed policies, procedures and processes 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.
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. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were

Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff provided examples of the involvement of Advocacy Services.
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, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. 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/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how lodge a complaint. The complaints register reviewed showed that complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans show any required follow up and improvements have been made where possible. The facility manager, with support from the clinical services manager and head office support, is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been several complaints received from external sources since the previous audit, with the service implementing corrective actions to make improvements to the areas identified.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in main entrance areas together with information on advocacy services, how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. 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. 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.
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	Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs and this was evidenced throughout residents' long term care plans. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respected their individual cultural needs.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, 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. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included discussions between staff, relatives and residents.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their/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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to speak English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Palms Lifecare is operated by Heritage Lifecare Limit (HLL). The operating systems, including monitoring systems, policies and procedures are centralised across the HLL group. Palms Lifecare has been going through a change management process since HLL commenced operation of the service. The business plan for 2017-18 contains the organisational mission, values and goals. The plan is reviewed on an annual basis. There are HLL goals, as well as site specific goals for Palms Lifecare. There is ongoing monitoring through weekly operations reports to the HLL senior management, monthly clinical/quality indicators, and monthly quality meetings. The service provides rest home and hospital level of care for up to 123 residents. The service plans to convert 38 rooms in the existing rest home (42 beds) to dual service beds (either rest home or hospital care). There are two adjacent buildings, one being a two storey building that provides rest home and hospital level of care for up to 60 residents. The other building currently provides rest home level of care for up to 63 residents. At the time of audit there were 57 residents in the rest

		home building (all rest home level of care) and 48 residents in the dual-purpose building (38 hospital, 8 rest home and 2 younger people). Services are provided to meet the individual needs of each of the residents. Palms Lifecare is located within a wider retirement living complex. The service delivery to the rest home/hospital is separated from the retirement living community. The Palms Lifecare management consists of a facility manager and a clinical services manager. Job descriptions were sighted for both roles. The facility manager has the overall responsibility for the entire complex (including the retirement village) with the clinical service manager having the clinical oversight for the rest home and hospital services. There is an interim registered nurse in the clinical nurse manager role till the role can be filled permanently. The facility manager has a background with management of disability services. Both the facility manager and interim clinical services manager are suitably qualified and experienced to perform their respective roles. In addition to the onsite management team, Palms Lifecare has support from the senior management team at HLL. The facility manager has attended over eight hours' education in the last 12 months related to management of aged care services. The residents and families report satisfaction with the services provided at Palms Lifecare.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The organisational chart identifies the facility manager is replaced by the clinical nurse manager during temporary absences. In addition to the clinical services manager taking on the role, support is provided by Heritage Lifecare Limited head office. Heritage Lifecare Limited does have a designated nurse manager who can take on the management role during temporary absences. Heritage Lifecare Limited has a monitoring process to support clinical staff transition to management roles and responsibilities.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident, family and staff satisfaction survey, monitoring of outcomes, clinical incidents including infections and pressure injuries. Palms Lifecare has been transitioning to the HLL quality and risk system since they began the operation of the service. The HLL quality and risk system has been fully implemented since May 2017, with quality indictor monitoring since October 2016. Meeting minutes and reports sampled confirmed weekly and monthly review and analysis of quality indicators and that related information is reported and discussed at the quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and meetings. The staff interviewed reported that they have seen

		positive changes with the implementation of the HLL quality systems. The HLL internal audit schedule was commenced in May 2017, with the facility manager reporting that Palms Lifecare will also conduct the internal audits that are on the plan from January to Aril 2017. From the internal audits and quality data sampled, relevant corrective actions have been developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent resident, family and staff survey showed actions have been implemented to address issues identified. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI assessment tool and process and pressure injury management. 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. As Palms Lifecare have been transitioning to the HLL policies and procedures, education has been conducted with staff to inform them of the changed policies and procedures. The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The hazard register was sampled. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse and near miss events on an accident/incident form and the electronic database. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the Palms Lifecare management team, as well as the HLL senior management. The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been several notifications of significant events made to the relevant authorities (section 31 notifications) since the previous audit. These motivations were related to pressure injuries, corners inquest, police infestations and wandering residents. The notifications sampled evidence appropriate corrective actions have been implemented.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in	FA	Professional qualifications and annual practising certificates (APCs) are validated on employment and annually. The service maintains a folder of current APCs, sighted for all staff and contractors who require them. The staff files evidence that appropriate employment processes are implemented, such as,

accordance with good employment practice and meet the requirements of legislation.		recruitment, interview and reference checking. Performance reviews are conducted after three months of employment, then at least annually, as confirmed in the staff files reviewed. There is a schedule and timetable for managing performance reviews through the year. There is an initial three-day orientation to the service that all new staff complete. There is then role specific orientation for the different roles within the service. The initial general orientation includes: the essential and emergency systems; handling concerns and complaints; cultural best practice; infection control; incidents/accident reporting; managing challenging behaviours; and restraint minimisation. Each staff file reviewed evidenced an orientation and induction into their role. Staff reported that the orientation and induction gave them a good understanding of their role and responsibilities. The service has access to an in-service education programme and external education that is appropriate to the level of care provided. The education plan covers the required contractual education, as well as specific education related to the needs of the service and the resident care. There are three RNs and the clinical services manager who are trained and competent to undertake interRAI assessments. A further two RNs have commenced the training, with another two RNs booked to start the interRAI training. The education is appropriate to cover the needs of residents for the proposed increase in the number of residents at hospital level of care. Staff reported that they are supported and encouraged with maintaining their knowledge and skills.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is clearly documented policy on staffing levels and skill mix to meet the needs of residents requiring rest home and hospital level of care. The staffing numbers are based on safe staffing indicators. Heritage Lifecare Limited provide a report to the facility manager to ensure the staffing skill mix complies with safe staffing indicators. The rosters sampled meet or exceeded contractual requirements for the different levels of care and resident's needs. There is at least one staff member on duty each shift who has current first aid qualifications. There is appropriate staffing level for activities, cooking, cleaning and laundry. Staff are replaced for annual and sick leave. The facility manager reported that staffing levels and skill mix will increase as the hospital level of care resident numbers increase with the proposed reconfiguration of bed usage. There is planned to be a registered nurse on duty 24 hours a day, when hospital level of care commences. The caregiving staffing will also increase in a staged process to match the increase in the hospital level of care. The Palms Lifecare and HHL management team members interviewed reported that the safe staffing level indicators will be met as the increase in hospital level of care increases.

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 includes interRAI assessment information and electronic databases. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
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	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. 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 NASC and GP for residents accessing respite care. 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. Service charges comply with contractual requirements. The facility has contracts to provide rest home, hospital, and respite care. On the day of audit there were 65 residents receiving rest home level care and 38 residents receiving hospital level care along with two residents under the age of 65 years.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's '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. At the time of transition between services, appropriate information 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 evidence of verbal and written handover and communication with the NASC team. Family of the resident reported being kept well informed during the transfer of their relative.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The current systems and methods for providing residents medication needs are suitable for the provision of increase in hospital level care. There are no proposed changes to the medication systems. 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. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug registers provided evidence of weekly and six monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart. There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner when required. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by a kitchen manager, cooks and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was last reviewed by a qualified dietitian 24 April 2016. Recommendations made at that time have been implemented. The current systems and methods for providing residents' nutritional needs are suitable for the provision of increased hospital level care. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The kitchen manager and facility manager

		stated that are working with the district council to have an approved food safety plan and registration issued by July 2017. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. 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. Staff have recently completed a 'master class' in pureed food, and plan to have moulded texture modified food to increase residents' satisfaction in presentation. Special equipment, to meet resident's nutritional needs, is available. The facility has two kitchens. The kitchen manager stated that the rest-home kitchen flooring is due to be fully renovated The April 2017 resident satisfaction survey showed that 79% of residents were overall happy with the food service. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
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 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. 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, nutritional screening and depression scale, 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 an interRAI assessments completed by three trained interRAI assessors on site. Two RN's are currently in training and two further staff are booked for upcoming training. There are ten interRAI assessments that are due to be completed this month. Five of those interRAI assessments are completed but remain in draft awaiting assessor sign of and the remaining five are due to be completed this week. Residents and families confirmed their involvement in the assessment process.

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 evidence 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 provision of 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 care is very good. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level 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.	FA	The activities programme is provided by three trained diversional therapists holding the national Certificate in Diversional Therapy. 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 three monthly and as part of the formal six monthly care plan review. The current systems and methods for providing residents recreational needs are suitable for the provision of an increase in hospital level care. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys. Residents interviewed confirmed they find the programme enjoyable.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the

timely manner.		service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
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 mental health services for older persons, and the NASC team. The resident 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 harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There is a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation. Chemicals are securely stored in the laundry area. There is appropriate personal protective equipment (PPE) and clothing in the laundry and cleaning areas. The education related to handling of waste or hazardous substances is part of the orientation and ongoing in-service education programme. The manager reports that it is not envisaged that there will be a need to make changes to the management of waste and hazardous substances as part of the reconfiguration of bed usage.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Each building has a current building warrant of fitness displayed. There are no required changes to the building as part of the reconfiguration of bed usage. Hot water temperatures have been monitored monthly, these being within safe guidelines. Medical equipment has annual calibration, last conducted within the last year. The electrical equipment is test and tagged. The annual service of the wheelchairs and hoist was sighted. The maintenance worker conducts a monthly compliance check of the environment. The environment promotes safe mobility, with secure hand rails in the hallways and floor surfaces that are intact and do not present a trip hazard. Each wing has access to external areas. The residents reported satisfaction with the environment.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	Each building has sufficient toilet and showers is each of the wings. The rooms in the rest home building have ensuite toilets and basins, with additional disability accessible shared toilet and showering facilities. The amenities across the service are suitable for residents at rest home or hospital level of care.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All the 38 rooms for reconfiguration are large enough for the needs of residents at rest home or hospital level of care. There is adequate space in the rooms for the resident, staff and mobility equipment. The rooms have wide doors in which mobility equipment can be manoeuvred through. Each resident's room visited had the resident's personal items, and provided enough space for the resident to mobilise and staff to perform their duties. The residents and families reported satisfaction with the personal space.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Each building has separated lounge and dining areas. There are several small lounges and sitting areas throughout the service. Residents' rooms also provided areas for residents to relax or entertain in privacy. The residents' report satisfaction with the access to dining and lounge facilities.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The cleaning and laundry is conducted by specific housekeeping staff. The facility manager reports that it is not envisaged that there will be a need to make changes to the cleaning and laundry services because of the reconfiguration of bed use. There are adequate processes in place for ensuring the cleanliness and sanitising of the reusable equipment (such as bed pans). There is secure storage of the bulk chemical supply in the laundry area. Staff demonstrated knowledge on the use of chemicals. The laundry and cleaning processes are monitored for effectiveness through the internal audit programme and resident/family satisfaction surveys. The residents reported satisfaction with the

		cleaning and laundry services.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an approved evacuation scheme for each of the buildings. There will be no changes to the layout of the building with the reconfiguration of the bed usage. The fire and emergency equipment has a monthly inspection as well as annual certification by an external contractor. Emergency and security training is provided as part of staff orientation and ongoing in-service education. Evacuation drills are conducted at least six monthly. Staff demonstrated knowledge on how to respond in emergency or civil defence situations. The service has bottled gas for cooking and emergency lighting in the event of mains failure. There is a water tank and bottled drinking water that is accessible in emergency situations. Each room, toilet and bathing facility has access to a call bell. The call bell system has a light and audible alert through a pager system, when activated. Staff responded promptly when the call bell was tested. The residents reported satisfaction with the time frames in which call bells are answered. A night staff member has a checklist to ensure the entrances, doors and windows are secure. Staff and residents reported satisfaction with the security arrangements. The entrances and car park are monitored by a security camera system. There is signage to notify people that there is a security camera system installed.
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 areas used by residents and families are ventilated and heated. Each resident's room and hallway have central heating and at least one window or sliding door for light and ventilation. The residents reported satisfaction with the heating, lighting and ventilation.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and	FA	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, with input from the infection control nurse and interim clinical nurse manager. The infection control programme and manual are reviewed annually. The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined

visitors. This shall be appropriate to the size and scope of the service.		in a job description. Infection control matters, including surveillance results, are reported monthly to the interim clinical nurse manager, and tabled at the quality/risk committee meeting. This committee includes the interim clinical nurse manager, IPC coordinator, the health and safety officer, and representatives from food services and household management. 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. Staff interviewed understood these responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator is three weeks into to her role and has appropriate skills, knowledge and qualifications. The interim clinical nurse manager states that the IPC nurse is booked to undertake external training in infection prevention and control in July 2017. Additional support and information is accessed from the interim clinical nurse manager, 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. The IPC coordinator confirmed the availability of resources to support 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 reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in April 2017 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. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and

education on infection control to all service providers, support staff, and consumers.		evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. 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, increasing fluids during hot weather.
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. The IPC coordinator reviews all reported infections and these are documented. 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 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 clinical manager/quality, IPC committee and at staff meetings. Data is benchmarked externally with other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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 enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and responsibilities. On the day of audit, no residents were using restraints (there is no recorded restraint use in 2017). One resident was using an enabler. The enabler is the least restrictive and used voluntarily at the resident's request. Restraint is used as a last resort when all alternatives have been explored.

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.

No data to display

End of the report.