

# Heritage Lifecare (BPA) Limited - Elizabeth R

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## 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 (BPA) Limited

**Premises audited:** Elizabeth R

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

**Dates of audit:** Start date: 17 January 2018      End date: 18 January 2018

**Proposed changes to current services (if any):** The facility is being sold and this provisional audit is being undertaken to establish the prospective owner's preparedness to provide a health and disability service and the current level of conformity with the required standards.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 25

# Executive summary of the audit

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## 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

Elizabeth R in Stratford provides rest home and hospital level care for up to 38 residents – twenty-three rest home and fifteen hospital residents. The service is presently operated by Bupa Care Services NZ Limited and managed by a care home manager and a clinical manager. On the days of the audit, there were 25 residents. One wing is presently closed due to the facility wide upgrade underway to repair the 'leaky building'. A spot surveillance audit had been conducted as required in November 2017.

A provisional audit was undertaken to establish the prospective owner's preparedness to provide a health and disability service and the level of conformity with the required standards. The audit was conducted against the Health and Disability Services Standards and the provider's contracts with the Taranaki District Health Board (TDHB). The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau, management, staff, a general practitioner, and the prospective owner.

This audit has resulted in two areas requiring improvements. These relate to completion of orientation appraisals and documentation of the daily kitchen cleaning. Since the previous surveillance audit, improvements have been made to the documentation of interventions in care plans.

## **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 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 resident's needs.

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

## **Organisational management**

Bupa have developed business and quality and risk management plans outlining the goals and values of the organisation. Monitoring of Elizabeth R service provides effective information to the wider Bupa organisation to assist in benchmarking of its

performance against its other services. An experienced care home manager is an enrolled nurse who been in the role for three years. Relatives and residents all spoke positively about the caring staff and homelike environment in the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and engaged in improvement activities and feedback is sought from residents and families. Adverse events are documented in a newly introduced electronic system. Actual and potential risks, including health and safety risks, are identified and mitigated. Current policies, procedures and records support service delivery.

The appointment, orientation and management of staff is based on current good practice and supported by a national human resources team. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

## **Continuum of service delivery**

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**

The facility meets the needs of residents, with spacious communal areas and private spaces. It is undergoing extensive external repair and some internal refurbishment. There is a current building warrant of fitness. Communal and individual spaces are maintained at a comfortable temperature. There are records of electrical and biomedical equipment testing being undertaken.

External areas are accessible to residents with mobility aids and seating and shade is available.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and is 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. Residents reported a timely staff response to call bells and this was observed. Security is maintained.

## **Restraint minimisation and safe practice**

The organisation has implemented policies and procedures that support the minimisation of restraint. One enablers and three restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process occurs, with regular review and evaluation. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes and proactively minimise the use of restraint.

## Infection prevention and control

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	48	0	2	0	0	0
Criteria	0	99	0	2	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 and include advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form and this was evident in five of five residents' files reviewed. Where a resident is deemed incompetent to make an informed choice, the enduring power of attorney (EPOA) will consent on behalf of the resident. Staff were

		observed to gain consent for day to day care. Documented discussions and verbal consent obtained between the facility, family and resident were sighted in the progress notes for four residents who were required to temporarily move bedrooms due to the current building construction. The facility also sent a letter updating all residents and their families about the construction of the facility and any changes that would need to occur to maintain the safety of the residents and staff.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were 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. The home care manager provided examples of when they the involvement or encourage the support of the Advocacy Services. The facility also acknowledges a resident advocate who lives in the community and attends and facilitates the regular residents' meetings.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The Bupa complaints policy and associated forms meet the requirements of Right 10 of the Code. The care home manager is responsible for complaint management. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Feedback 'Unhappy with our service' forms are available at the reception.</p> <p>The complaints register reviewed showed seven complaints were received in 2017, all of which were acknowledged, investigated and</p>

		<p>satisfactorily followed up and resolved in the required time frames. Residents and families spoken to knew about the process and were comfortable raising any concerns. Information is provided in the entry pack of information for new residents. There is also a register of compliments maintained which indicates a high level of satisfaction with the service.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There are no known Health and Disability Commissioner or complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>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 from discussions with staff. The Code is displayed in the main reception of the facility together with information on advocacy services, how to make a complaint and feedback forms. The prospective provider is an experienced aged care sector provider who understands the Code. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the requirements of the Code as part of their existing roles.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room, or share a room (please see Standard 1.4.4). The home care manager interviewed stated that the sharing of the ensuite and kitchenette is discussed at the time of admission and verbal consent obtained. Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor, and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</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.</p>
<p><b>Standard 1.1.4: Recognition Of Māori Values And Beliefs</b></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>The facility interviewed stated that there is one resident who affiliates with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori, with staff able 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 whanau. There is no specific current Māori health plan, however all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model of care evidenced in the care summary, in the map of life, and in the interRAI assessment and long-term care plan. There is input from cultural advisers within the local community who also provide guidance on tikanga best practice. The Māori resident was unavailable to be interviewed, however their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</p>
<p><b>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</b></p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>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.</p>
<p><b>Standard 1.1.7: Discrimination</b></p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered and enrolled 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.</p>
<p><b>Standard 1.1.8: Good Practice</b></p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health</p>

Consumers receive services of an appropriate standard.		<p>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. One of six general practitioners interviewed 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 maintain contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members 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.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English, staff able to provide interpretation as and when needed, and the use of family members.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Elizabeth R provides hospital (geriatric and medical) and rest home level care for up to 38 residents. On the day of audit, there were 16 rest home level residents and nine residents receiving hospital level care. Respite care residents are also accepted when there is bed availability.</p> <p>Bupa operates with a defined vision and goals which are clearly promoted in the facility. Annual Bupa goals are established each year, with 2018 goals under development and awaiting approval. Two national goals are implemented and two local priorities are set each year in relation to quality and risk management.</p> <p>The service is managed by a care home manager, who has been in the role since 2014. She is an enrolled nurse with extensive experience in the sector. She is known in the region for chairing the aged care forums and positive aging expos. She has been recognised</p>

		<p>through nomination as a Bupa Rest Home Manager of the year in 2017. She attended the enrolled nurse conference and Bupa forums for managers in 2017 to undertake the minimum eight hours of professional development annually. She maintains clinical competency and has almost completed the Bupa professional development and recognition programme. She regularly participates in the Bupa group teleconferences and forums.</p> <p>The care home manager is supported by a clinical manager/registered nurse (RN) who has been in the role for 18 months. Both the care home manager and clinical manager are supported by a Bupa regional manager and wider support structure. On call arrangements are shared between the care home manager and clinical manager.</p> <p>The new provider is Heritage Lifecare Ltd (HLL) which is an established New Zealand aged care provider, currently operating more than 1100 beds in the sector. An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017). Elizabeth R is one of twelve proposed facility acquisitions across the country.. As of 30 January 2018 HLL has set up a new company to acquire and operate this group of new facilities. This company is Heritage Lifecare (BPA) Ltd. However for ease of reference the new provider is referred to as Heritage Lifecare Limited (HLL) throughout this report.</p> <p>The transition plan is led by an experienced and well-qualified project team who are specifically focussing on the integration of the current facilities into the Heritage Lifecare Ltd group. This includes provision of infrastructure support, such as providing information technology capability, including hardware and software. Regional workshops are planned to introduce documentation, and the new HHL systems and processes. This is planned to occur within the first three months. The project team is working with the BUPA team to ensure a smooth transition of each operation.</p> <p>The present senior team will remain in place at each facility during the transition period. It is anticipated that existing staff will transfer to the new provider.</p>
Standard 1.2.2: Service Management	FA	During the temporary absence of the Care Home manager, the clinical

<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>		<p>manager carries out all the required duties under delegated authority. There is also the option of support from a Bupa roving manager or a care home manager from another Bupa site located in the region.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned and implemented quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint use, and is linked to the facility's operation.</p> <p>Quality and risk data, including trends in data and benchmarked results are discussed in registered nurse, staff and quality risk/health and safety meetings and reported monthly in the manager's report. Any new issues are discussed at the managers' weekly teleconference. Review of the meeting minutes confirmed regular review and analysis of quality indicators, such as falls, pressure injuries, health and safety, restraint use and infections. Information, including audit results, are reported, and operational matters discussed at the meetings attended by management, staff and registered nurses. Meeting minutes are displayed in the staff room. Staff also report their involvement in quality and risk management activities by undertaking audit activities. Corrective actions are planned and implemented to address any service shortfalls. Resident and family satisfaction surveys are completed annually, with feedback used to plan improvements. Together with the 2017 staff survey, results indicate high levels of satisfaction. An annual internal audit plan/schedule and audit results evidences internal audits are planned to occur on a regular cycle, and are linked to specific problem areas.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements. Policies are based on best practice and were current. A nationally implemented document control system ensures systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. One hard copy folder of all documents is available in the facility, with all master documents held electronically.</p> <p>The care manager described the processes for the identification,</p>

		<p>monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented on site requirements. Health and safety is discussed at the two-monthly quality and risk meeting.</p> <p>The new provider confirmed that during the transition phase, HLL policies and procedures will be introduced. By the end of 2018, a new software system will be introduced to incorporate risk management which includes adverse event reporting, care planning and client management. Meanwhile, the electronic BUPA system will be superseded by HLL documentation and will be reliant on hard copies on site until the electronic system is fully implemented. This is anticipated to be within six months of the purchase.</p> <p>HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure. A key strategy to introduce a national clinical governance group is planned in the next 12 months.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>In late 2017, a national electronic risk management system was introduced to the Elizabeth R site. It is used to capture and analyse adverse and near miss events. Information about any adverse event is entered into the system, along with any subsequent actions or follow up. Facility adverse event data is collated, trended over time and reported each month to Bupa for benchmarking across the Bupa services. Reports sighted highlight any areas which are above the national benchmarks or there is a variance since the previous report.</p> <p>Family are routinely notified following clinical incidents and this is recorded in the clinical record and electronic system. The care manager described essential notification reporting requirements. There have been no notifications of significant events made to the Ministry of Health, Worksafe NZ, professional bodies, police or Coroner since the previous audit.</p>

		<p>There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The national quality manager interviewed could verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements for event reporting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Bupa has human resources management policies and processes based on good employment practice and relevant legislation for the recruitment and selection of staff. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of seven staff records confirmed the organisation's policies are being consistently implemented and records, including signed job descriptions and employment contracts, are maintained. Personnel files are systematically organized.</p> <p>Staff orientation includes all necessary components relevant to the role. Caregivers undertake the standard Bupa induction which provides the staff member with a Foundation NZQA level 2 qualification at the end of their three-month orientation period. Registered nurses are initially supernumerary. Other staff groups also have specific structured orientation programmes. Staff reported that the orientation process had prepared them well for their role in the team. An annual performance review system is in place, with one staff member still to complete their 2017 appraisal. Not all staff have completed their orientation appraisals in the specified time frames (see 1.2.7.5). A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>Bupa plan continuing education on an annual basis, including workshop sessions for some of the compulsory and core training requirements each quarter. Staff also participate in external training provided by Hospice Taranaki and the DHB. Attendance at mandatory training can be demonstrated through the attendance register maintained for each training session and staff have an individual annual record of training on file. Records reviewed demonstrated completion of the required training. Additional 'toolbox talks' are presented for topical issues.</p>

		<p>An annual competency, including individually completed workbooks where appropriate, is implemented – examples include moving and handling, restraint, and workplace first aid or equivalent. A first aid session for twenty staff is scheduled for March 2017, with the intention of having a core of staff who are first aid competent. Registered nursing staff all hold current first aid certificates. Competencies for registered nurses includes medication, catheter care, wound management and syringe drivers. Records are maintained. A focus on upskilling all care staff to level three occurred in 2017. This resulted in seventeen staff achieving their level 3 qualification. Household staff undertake relevant training, as the small staff group frequently work across many different roles in the facility.</p> <p>There are currently six of 10 registered nurses who are maintaining their annual competency requirements (sighted) to undertake interRAI assessments. The care home manager states the intention is to train all the current registered nurses as soon as places are available. The clinical manager has completed the Bupa professional development and recognition programme, with a further portfolio submitted. Three other staff including two enrolled nurses are working on their portfolios.</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) to meet contractual requirements. The facility adjusts staffing levels to meet the changing needs of residents and acuity, however, there is no link between interRAI acuity and staffing levels at this point. The care home manager and clinical manager share call out of hours. Staff report that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them, with workload reallocated when required. Residents and family interviewed supported this. Observations and review of a three two-week roster cycles confirms adequate staff cover has been provided, with staff replaced in any unplanned absence. The registered nurse on duty holds a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage in the hospital. An activities coordinator oversees the activities programme, a maintenance person is available three days per week and visiting health professionals (such as the palliative care liaison nurse and physiotherapist) provide additional</p>

		<p>support to resident's health needs.</p> <p>The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the Guidelines for safe staffing level and indicators. The representative for HLL interviewed could confirm understanding of the required skill mix to ensure rest home and hospital care residents' needs are met. The organisation already provides the range of levels of care (geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>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 entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system, however were not accessible at the time of audit due to the building currently under construction. The home care manager interviewed stated that older records are held off site by the organisation and in a secure location and were not able to be viewed at the time of audit.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter 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/or 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</p>

		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.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>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 of a patient transferred to the local acute care facility showed the use of the 'yellow envelope' and supportive documents, and communication between the facility. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<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) and paper based system for six of 25 residents (due to one of six GP's preference) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p>

		<p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There were two residents self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</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 kitchen manager and a 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 however the day to day cleaning schedule sign off for the kitchen was not documented. The service operates with an approved food safety plan and registration issued by the local council that expires 22 September 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen 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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting</p>

		minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the home care manager interviewed stated that if this situation was to occur information is provided about other facilities in the local area. The local NASC is also 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. There is no known history of residents being declined to the facility. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, challenging behaviours and a depression scale as a means to identify any deficits and to inform care planning, when the resident is initially admitted to the facility. The sample of care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed by one of five trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>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 and ongoing discussions with families were reflected in care plans reviewed.</p> <p>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</p>

		care plans.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their individual 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 including residents that were admitted with their spouse and families that visited daily whom wanted to support with some daily activities of living for their family member. One GP interviewed verified that medical input was sought in a timely manner, that medical orders were followed, and care was 'excellent'. 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.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme (who was not available at time of audit) is provided by an activities co-ordinator who has completed training through Careerforce and the organisation and works Monday to Friday 9am to 4pm. Three of those days include the pickup and drop of off day care residents and the activities co-ordinator is then responsible for day care residents care also.</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 three monthly and as part of the formal six- monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities of which the locals in the community are invited to and actively partake in. Individual, group activities and regular events are offered. Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents and families interviewed confirmed they find the programme 'fun and interactive'.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the 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 and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a '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 physiotherapy, hospice, and a clinical nurse specialist. 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.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. This occurred at the end of 2017. Material safety data sheets are available where chemicals are stored and these were correctly and clearly labelled. Staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment</p>

		and staff were observed using this.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 9 July 2018) is publicly displayed in the entrance to the facility.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and are adequately maintained. Presently, there is a major project underway (Project recladding) which is being undertaken in 5 stages to address a 'leaky building' repair and some refurbishment. This is due for completion at the end of March 2018. Building consent (issued 13/11/17) and a Certificate of Public Use was issued 17/11/17 for this work. This is a large project, necessitating the progressive closure of various areas, with one wing presently closed to facilitate this work. Contingency planning is in place, however there are challenges with suitable storage, building dust and clutter during this period, which are being well managed. Suitable health and safety precautions and contractor inductions are being managed on a daily basis throughout the project.</p> <p>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. The facility van is booked for a hoist check on 22nd January. The environment is hazard free, with areas safely blocked off from residents and staff during the project.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. There is a large outdoor area with raised gardens, seating and shade. Internally, corridors are sufficiently wide for residents to safely mobilise. There are designated outdoor smoking areas for residents and staff.</p> <p>Staff confirmed sufficient equipment to provide the necessary care to residents. There is an organisation wide process to update or replace equipment at the end of its useful life. Presently, three facility hoists are being replaced. Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with their environment. Reactive repairs and maintenance are undertaken on</p>

		<p>request by on-site maintenance personnel.</p> <p>HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each facility. There are presently no plans for any environmental changes in the facilities.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></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. This includes shared ensuites in C and D wings. Additional bathrooms are located near residents' rooms in A wing. This includes a large access enabled toilet, two other toilets and a separate shower room. Commodes are also provided if necessary. Bathrooms have intact wall and easy to clean floors and surfaces. Some refurbishment and minor upgrading is planned as part of the refurbishment currently underway. There are no privacy locks on the communal toilets or showers, however all doors have signage which was observed to be used by residents and staff to indicate when the room is in use.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></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. Bedrooms provide single or shared accommodation which is separated by a bathroom and small kitchen space. Curtaining provides visual privacy when rooms are shared. Where rooms are shared, approval has been sought from residents to share the space. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids and wheel chairs, although storage is severely limited during the recladding and refurbishment project. Staff and residents reported the adequacy of bedrooms.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation,</b></p>	FA	<p>Communal areas are available for residents to engage in activities,</p>

<p>And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>read or watch television. The dining and two lounge areas are spacious and enable easy access for residents and staff, with plenty of space for residents to move around safely with or without mobility aids. Residents can access areas for greater privacy, if required. Residents are observed to use a variety of spaces during the day, for quiet activities or to entertain visitors. Furniture and seating is appropriate to residents' needs and designed to encourage their independence.</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>	FA	<p>Laundry is undertaken on site or by family members, if this is requested. Care staff have allocated laundry time to undertake laundry tasks and demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. A 2017 complaint in relation to lost clothing has been satisfactorily addressed.</p> <p>The cleaning team have received appropriate training, with several staff trained to work in the kitchen, laundry or to undertake cleaning roles. This strategy has been well received by staff and provides a competent core team. These staff are undertaking the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. The cleaning trolleys are stored safely when not in use.</p> <p>Chemicals are provided by an external contractor. Cleaning and laundry processes are monitored through the internal audit programme completed as part of the internal audit schedule. The most recent laundry result in January 2018 achieved 98.5% against defined standards. Residents and families interviewed are satisfied with these household services.</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>	FA	<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. The care home manager has undertaken CIMS</p>

		<p>(coordinated incident management system) training. The current fire evacuation plan was approved by the New Zealand Fire Service on the 14 April 2016. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 16 October 2017. The 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 BBQ's were sighted and meet the requirements for the number of residents accommodated in the facility. Sufficient quantities of additional water are stored in the complex and renewed regularly. Emergency lighting is regularly tested including during a recent power outage.</p> <p>Call bells in bedrooms, bathrooms and communal areas alert staff to residents requiring assistance through strategically placed indicator boards. Residents and families reported staff respond promptly to call bells and timely responses were observed during the on-site audit</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a community security patrols visit and checks the site at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Records of environmental temperatures and interviews with residents and families confirmed the facilities are maintained at a comfortable temperature. However, improvement will occur as part of the current upgrade project, with double glazing being installed throughout. Thermostatically controlled electrical heating is installed throughout the facility. Rooms have natural light with opening external windows. There is flat access to the outdoor garden and lawns with shade available. There is a designated external smoking area.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>infection control manual, with input from the organisation's operations manager who is a registered nurse, and quality services improvement team. The infection control programme and manual are reviewed annually.</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 at the monthly infection control committee meeting and staff meetings. This committee includes the facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Staff discourage visitors from visiting the facility when unwell. 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.</p> <p>Infection control measures have been discussed and implemented in relation to the construction programme on site and evidence was provided that this has been identified in the hazard register. The night cleaning schedule for facility staff has also been reviewed and updated accordingly. The home care manager interviewed stated that she also regularly visits areas of the facility which are under construction to ensure that risks to residents and staff continue to be minimised at all times.</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>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role and has been in this role since April 2016. She has undertaken certificates in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is 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>

		The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.
<p><b>Standard 3.3: Policies and procedures</b></p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>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 2017 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>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 evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p>
<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, eye, gastro-intestinal, the upper and lower respiratory tract, and wound infections. 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.</p>

		<p>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 at 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 home care manager, clinical manager and the organisation as a whole. Surveillance records showed the facility had six residents in June and seven residents in July of 2017 diagnosed with a respiratory tract infection and commenced on antibiotics. A corrective action was put in place and interventions implemented reduced the number to two residents in August. Benchmarking within the group has provided assurance that infection rates in the facility are below average for the sector with a total of 22 episodes of residents treated with antibiotics for an infection over the last six months.</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 enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and his role and responsibilities. There is a signed job description.</p> <p>On the day of audit, three residents were using restraints and one resident was using an enabler which was the least restrictive method and used voluntarily at their request. A similar assessment process is followed for the use of enablers as is used for restraints.</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.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on</p>	FA	<p>Approved restraint is consistent with the Bupa policy. It is evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall</p>

restraint use and this process is made known to service providers and others.		<p>use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care. Restraint use is reviewed through internal audits, facility meetings, and regional restraint meetings, with results benchmarked across the organisation. Staff maintain annual competency in the use of restraint and enablers.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of all restraint were documented using Bupa templates for three residents and included all requirements of the Standard. The clinical manager/RN undertakes the initial assessment with input from the resident's family/whānau/EPOA and general practitioner. The restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives trialed and any associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint and interRAI assessments reviewed also identifies any risk and need for restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members. There was an example of the trial of alternatives to restraint for a resident, such as a lazy boy chair, landing mat, ultra-low bed and increased monitoring of the resident.</p> <p>When restraints are in use, frequent monitoring according to the assessed risks occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all restraint processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed</p>

		<p>and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use. Competencies are included at orientation and annually thereafter.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, three monthly restraint evaluations, and at the regional restraint approval group meetings. Frequency of evaluation occurs according to the assessed risks. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process and the option to have input at the multidisciplinary team meeting which includes review of restraint.</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. Overall, there has been an organisation wide reduction in the use of restraint year on year.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The regional restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Restraint meetings and reports are completed and individual use of restraint use is incorporated and reported to the quality/risk 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. The December meeting includes reference to a new restraint. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education</p>

		<p>and processes are implemented if indicated.</p> <p>A recent restraint incident occurred when another resident released a lap belt for a person using a lap belt, resulting in a fall without injury for both residents. Data reviewed, minutes and interviews with registered nurses and care staff confirmed that the facility is proactive in promoting alternatives to restraint and its use has been gradually reducing over the past three years.</p>
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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)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There is an implemented system for performance appraisals which are undertaken by the care home manager and clinical manager. Staff appraisals are current except for those undertaken during the orientation period at 30, 60 and 90 days for RN's and caregivers and at six weeks and 12 weeks for household staff. Two of seven have not been completed in the required timeframe in the files sampled. An annual appraisal for a casual caregiver has not been completed in the 2017 year.</p>	<p>Orientation appraisals are not consistently completed in the time frame and one annual appraisal for a casual staff member is overdue.</p>	<p>Ensure appraisals are completed in the required time frames.</p> <p>180 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current</p>	PA Low	<p>The facility has a very low infection rate and on observation the kitchen appeared clean. The residents and families interviewed stated that they were very happy with the meals provided. The kitchen manager interviewed stated that they clean the kitchen on a daily basis. There was evidence</p>	<p>There is no documented evidence that the day to day cleaning schedule in the kitchen is being implemented.</p>	<p>Provide evidence that a cleaning schedule is maintained in the kitchen to comply with safe food hygiene standards.</p>

legislation, and guidelines.		that the night and monthly cleaning tasks for the kitchen was being completed. A day to day cleaning schedule of the kitchen was provided, however there was no evidence that the schedule was being implemented.		180 days
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# Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.