

Heritage Lifecare (BPA) Limited - Flaxmore Care Home

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 (BPA) Limited

Premises audited: Flaxmore Care Home

Services audited: Dementia care

Dates of audit: Start date: 17 January 2019 End date: 18 January 2019

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 40

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

Flaxmore Lifecare provides rest home level dementia care for up to 50 residents. The service is operated by Heritage Lifecare (BPA) Limited and managed by a facility manager and a clinical services manager. Family members spoke positively about the care provided and are satisfied with the service.

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

This audit has resulted in three continuous improvement ratings, one of which relates to the admission process; one regarding clinically focused quality improvements and the other is related to changes to the external environment that are enhancing the lives of the residents. The need for carpets in several areas to be replaced and for some staff performance appraisals to be completed, are areas requiring improvement that were identified.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents and their family members. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

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

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

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

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

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

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.		Some standards applicable to this service partially attained and of low risk.
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An organisational strategic plan, a Flaxmore Lifecare business plan and a comprehensive quality and risk management plan include the scope, direction, goals, values and mission statement of the organisation as well as short and long-term objectives. Regular monitoring of the services is occurring with relevant reports being provided to the governing body. Reviews of the quality and risk management system are ensuring accountability. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to ongoing improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented when required. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures that support service delivery are current and undergo ongoing reviews.

Human resources processes, which include the appointment, orientation and management of staff, are based on current good practice. Internal and external training opportunities are available, documented and support safe service delivery.

Staffing levels and the skill mix of staff meet the changing needs of residents.

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

Continuum of service delivery

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

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

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

The planned activity programme is overseen by two diversional therapists and provides residents with a variety of individual and group activities seven days a week and maintains their links with the community. A facility van is available for outings.

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The facility meets the needs of residents, was overall clean and well maintained. Rooms are of a suitable size and large dining and lounge areas enable easy movement. There is a current building warrant of fitness. Electrical equipment is tested and bio-medical equipment calibration checks are undertaken as required. Communal and individual spaces enable independence and the design of the building is used to promote opportunities for residents to mobilise around it with minimal restrictions. External areas are accessible, safe and include some special interest features.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing that is readily available. Chemicals, soiled linen and equipment are safely stored and managed appropriately. Laundry is undertaken onsite and cleaning and laundry processes are evaluated for effectiveness.

Staff are trained in emergency procedures and emergency supplies and equipment are available. Fire evacuation procedures are practised six-monthly. Call bells are available for use when required. Systems are in place to ensure security is maintained.

The building has suitable heating and ventilation systems and inside temperatures are monitored.

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.
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The organisation has implemented policies and procedures that support the minimisation of restraint and would guide any restraint use. The facility promotes a restraint free environment and there were no restraints, or enablers, in use at the time of audit. Appropriate processes are known about and relevant documentation is available, should the use of a restraint be required. Staff have completed training on the use of restraints and enablers, as well as on behaviours that challenge, and described key aspects on the topics during interviews.

Infection prevention and control

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

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	2	0	0	0
Criteria	3	87	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	Flaxmore Lifecare (Flaxmore) has policies, procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included 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	FA	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents' files reviewed had EPOAs in place and activated.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

consent.		
<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 and family members are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Resident meeting minutes are noted to inform residents and families of the availability of advocacy services if required. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family 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' families 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 comments/complaints and compliments policy, procedure and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is available at the front entrance by reception. Family members are provided with information at the time of their relative's admission and this is discussed in the presence of the prospective resident. There was awareness among people interviewed about the complaints process. Residents'/families concerns are taken seriously.</p> <p>A register of complaints was reviewed and showed that five had been received throughout 2018 and one since 2019 started. There is a recurring theme of the odour in the carpets (refer corrective action in 1.4.2.6). All complaints in the register have been followed through and responded to. Action plans showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. Review of correspondence related to a Health and Disability Commissioner complaint for an external service that has links with Flaxmore Lifecare shows the request for information has been responded to as required. This was not a complaint about the services provided by this facility.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents were asked about all aspects of consumer rights during this audit. At times however due to the residents medical circumstances the opinions of family members and enduring power of attorneys (EPOAs) was used to provide a consumer perspective. Residents and family members/whanau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with staff and visits by the local advocacy service advisor at resident and family meetings. The Code is displayed in common areas around the facility. A range of information brochures are available at reception, including brochures on the Code, information on advocacy services, how to make a complaint and forms that enable opportunities to provide feedback.</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 family members confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. This was observed in all levels of services provided, during the audit.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in activities of their choosing. Each lifestyle plan 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, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and</p>	FA	<p>There were no residents at Flaxmore at the time of audit, who identified as Maori. Interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed at organisational level with input from cultural advisers. A local Maori Health provider will provide Flaxmore with staff education and advise on meeting the needs of Maori residents if required.</p>

acknowledges their individual and cultural, values and beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and family members of Flaxmore verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, daily routines, previous lifestyle practices, required interventions and special needs were highly regarded at Flaxmore. Care plans provided detailed documentation around residents' individual needs, for example, religious practices, food likes and dislikes and attention to preferences around activities of daily living. National cultural days of significance to staff and residents are recognised and celebrated.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A visiting general practitioner (GP), hospice nurse and nurse educator from the Nelson Marlborough District Health Board (NMDHB) expressed a high level of satisfaction with the standard of services provided to residents at Flaxmore and the focus on the attention to meeting individualised needs.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>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, physiotherapist, wound care specialist and mental health services for older people.</p> <p>Leadership at Flaxmore is provided by an experienced management team committed to providing high quality individualised care to residents and enabling staff the opportunity to meet the resident's individualised needs. Clinical reviews are held weekly to ensure staff remain focussed on the resident's best interests.</p> <p>Caregivers are all trained or in training to care for residents with dementia. The nurse educator from the NMDHB</p>

		<p>on interview, identified the care provided by staff was at a level her teaching aspires to achieve. The philosophy of care at Flaxmore, seeks out reasons for residents presenting with behaviours that challenge those around them, and addressing the cause to maximise residents' comfort, in partnership with the family.</p> <p>An initiative to improve the oral health of the residents has been implemented; after it was identified comfort is compromised by this being not managed appropriately. Evidence was sighted of resident's behaviour and comfort improving after they had received the required oral care, by specialist services. Residents were enabled to enjoy their meals, eat their food and not be in constant pain. The initiative has highlighted the need for better oral care to be provided earlier, to minimise the potential of discomfort. It has also highlighted the potential that certain behaviours seen in residents with dementia may be related to poor oral health rather than the dementing process. This initiative is ongoing currently.</p> <p>The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks, such as on-line forums, to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included a commitment to providing individualised care, within an environment that focussed on the needs of the residents.</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 own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Photos are on display of the day to day activities by the residents. Newsletters are sent out every two months to keep family members informed, and family members are invited to the quarterly residents' meetings. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the NMDHB when required. Staff knew how to do this, though reported interpreter services were rarely required due to all present residents being able to speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned,</p>	FA	<p>Heritage Lifecare (BPA) Limited (HLL), the company that owns and operates Flaxmore Lifecare, last reviewed their strategic plan in 2018 and a copy was reviewed. The purpose, values, scope, direction and goals of the organisation are clear with a resident-focus approach evident. A business plan 2018 – 2019 was sighted and includes site specific goals for Flaxmore Lifecare. The plan provides direction and goals related to continuous quality improvement, the ongoing professional development of staff, developing and maintaining strong relationships with stakeholders and the intention to maintain occupancy at 95% or over. Operational plans sit</p>

<p>coordinated, and appropriate to the needs of consumers.</p>		<p>under annual and longer-term objectives. A comprehensive organisational quality and risk management plan is consistent with the strategic and business plans and described monitoring and evaluation processes for accountability purposes.</p> <p>Weekly reports are provided by the facility manager to the support office and monthly reports on clinical indicators are provided by the clinical services manager. Adequate information to monitor performance is reported including clinical quality indicators and key performance indicators related to issues such as occupancy, staffing, financial performance, and emerging risks and issues including adverse events and any non-compliance.</p> <p>The facility manager has been in the role at this facility for nearly four years. She is suitably qualified and experienced with diplomas in business and frontline management and management experience in hospitality and hotel management, human resources and the health sector. Of 38 years working in the aged care sector in Australia, 30 of these were within management roles. The facility manager is maintaining her professional development within her areas of expertise and attends the regional aged care District Health Board meetings. Responsibilities and accountabilities are defined in a position description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements. Currency is maintained through participating in on-site training, undertaking external professional development opportunities and maintaining regular links with local managers from similar types of services and organisations. The manager is a workplace assessor up to level four for Careerforce.</p> <p>The service provider holds contracts with the local District Health Board to provide rest home level dementia care only under the Aged Related Residential Care Agreement (ARRC) and respite care. It also delivers a Ministry of Health contract for Young Persons with Disabilities (YPD). On the first day of audit, there were forty residents receiving rest home level dementia care, three of whom were under the YPD contract. No residents were receiving respite care and there were ten empty beds.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to</p>	<p>FA</p>	<p>When the facility manager is absent, it is usually the clinical services manager who undertakes the required duties under delegated authority. The clinical services manager also has access to the operations / area manager at the support office for additional advice and support and to the HLL Quality Team, which has clinical representation. However, the facility manager noted she is seldom away for long and even while absent is generally in telephone contact.</p> <p>During absences of the clinical services manager, a senior registered nurse who was on leave during the audit, would share the load and has done so. Staff reported the current arrangements work well and that they consistently have sufficient access to advice and support when needed. Another facility nearby has recently been purchased by HLL and their team will be available for additional support if required.</p>

consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes responses to and management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, any use of restraints or enablers and quality improvement processes.</p> <p>Both monthly quality meeting minutes and monthly staff meeting minutes reviewed confirmed regular review and analysis of quality indicators. Related information is reported and discussed at the various meetings held. Staff reported their involvement in quality and risk management activities through participation in internal audits, attending meetings or reading minutes, making efforts to reduce the number of incidents and taking on roles such as health and safety officer. Relevant corrective actions and quality improvements are developed, documented on quality action forms and the plans implemented to address any identified shortfalls. Family / resident satisfaction surveys are completed annually; however, results of the first under HLL, which is also the most recent survey, were not available as the survey is still under way with results due in February 2019. Quality improvement initiatives in relation to daily, weekly and monthly analyses of clinical indicators is being undertaking at a level demonstrating continuous improvement with positive outcomes occurring for residents.</p> <p>Policies and procedures reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. Heritage Lifecare (BPA) Limited (HLL) are currently in the process of progressively reviewing all documentation to ensure it meets the needs of the facilities and is applicable for the introduction of the electronic recording systems that are progressively being introduced. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. A generic organisational risk register is in place and the facility manager reviews these alongside the risks specifically identified for Flaxmore Lifecare. Existing quality and risk monitoring systems cover most of the review requirements.</p> <p>The manager supervises the health and safety officer, who is a suitably trained senior caregiver and is responsible for ensuring the requirements are implemented. Relevant reports are presented to the monthly quality meetings. A hazard register is in place and there was evidence of ongoing reviews of this register.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned,</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. The facility manager follows up and manages incidents related to staff, while the clinical services manager follows up those related to residents. In the sample of incident forms reviewed, there was evidence of sign off and appropriate actions implemented when indicated. Open disclosure was 'ticked off' with the people spoken with noted. Incidents are investigated,</p>

<p>or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>action plans developed and actions followed-up in a timely manner. Incidents are registered on 'ECase', a recently introduced electronic review system and copies of incident forms are provided to the HLL support office. Adverse event data is collated and analysed at the local level and are a component of the clinical indicator data reports that goes to the HLL support office every month, where the information is further analysed. Many of the incidents in this facility are documented as being the result of resident related behaviours, although the facility manager and clinical services manager noted that when looking at causes, this often led back to staff not following expected procedures when managing a resident(s). Examples of changes made as a result of the analysis of incidents, such as people with multiple falls, has identified solutions with more than one person assisted to have an afternoon rest after it was identified multiple falls were occurring between 1pm and 4pm. This has resulted in a significant decrease in falls during this time frame.</p> <p>The facility manager described essential notification reporting requirements, with examples provided being for significant/sentinel events, infection outbreaks and insufficient staff to adequately care for residents. According to the facility manager there have been no notifications of significant events made to the Ministry of Health since the provisional audit approximately a year ago. It was noted that the support office is also to be advised of any such events.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>Human resources management policies and processes are based on good employment practices and relevant legislation. The current recruitment process includes referee checks, personal interviews, police vetting and validation of training and qualifications. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented for new staff being employed and that records are maintained. A file of Annual Practising Certificates showed these were being checked annually and copies of relevant documentation were available for all registered nurses, GPs, pharmacists, the podiatrist and the dietitian who are associated with the service.</p> <p>Staff orientation includes all necessary components relevant to the role and the checklist is signed off by the relevant department head. During interview, staff were positive about their orientation process and about the changes made to ensure staff are buddied by the same staff person for all of the buddied shifts they undertake. Staff records reviewed show documentation of completed orientation checklists. A performance review after a three-month period is now being undertaken and records of these were viewed for staff employed since HLL commenced. Appointments are scheduled for two other more recent employees.</p> <p>Continuing education is planned on an annual basis, according to a list of mandatory training requirements. A calendar of these requirements is updated when the training session(s) are organised, and the type of presentation is noted. Additional special interest topics are also organised as applicable. Individual staff may also request to undertake a specific external training if relevant to their role and examples of this were sighted. Attendance records are maintained, and a topic may be repeated if staff attendance is low. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the</p>

		<p>requirements of the provider's agreement with the DHB. All four registered nurses are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated overall completion of suitable staff training as required for dementia care services with introductory sessions provided to all new staff followed by their attendance at externally provided courses. Courses on managing various aspects of dementia care are also scheduled throughout the year. Not all staff annual performance appraisals were current, and this has been raised for corrective action.</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>The organisational policies on 'Safe Staffing of HLL Aged Care Facilities' and on the roster and time sheets provide guidance for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels are being adjusted to meet the changing needs of residents, including when there are changes in occupancy levels. Additional funding has been accessed to provide additional staff when acuity levels, including for palliative care provision for a person, have risen.</p> <p>A clinical services manager is on duty for eight hours Monday to Friday at the same time as another registered nurse. There is registered nurse cover until 11pm and that nurse takes the on-call phone home and is on call until the following morning. The facility manager is available for non-clinical on-call requirements. Care staff reported that they feel well supported by senior staff and managers. They also stated that there were sufficient numbers of staff available to complete the work allocated to them. If staff are experiencing heavier workloads and feel they need additional staff on a shift(s) they are invited to approach the manager and justify their request. The facility manager, in consultation with the clinical services manager, will oblige by providing additional staff, or lengthening what is referred to as the 'short shift' and monitoring the situation. Family members interviewed expressed confidence in the staffing levels.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence with people either from the casual pool or staff wanting additional shifts. Short shifts are evident to cover the busier timeframes. No agency staff are used at Flaxmore Lifecare. Staff with additional competencies, including for medicine administration and first aid, are identifiable on the roster. A team leader, who is a senior caregiver, is allocated on the roster for each shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p>

accessible when required.		<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>Electronic medication records are stored in a secure portal.</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 their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the clinical services manager (CSM). They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, authorities to provide services in a secure environment and signed admission agreements in accordance with contractual requirements.</p>
<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 NDHB '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. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	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 was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two</p>

		<p>staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>Medication errors are reported to the RN and CSM and recorded on an accident/incident form. The designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was developed by a qualified dietitian in November 2018.</p> <p>A food control plan is in place and was registered with the Nelson City Council in June-2018.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by observation, weight charts, resident and family interviews, and resident and family meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Residents were often seen wandering around and eating on the go, with staff providing food items in line with residents' interest. There were enough staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed. Residents have access to food and fluids at any time.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident/family are supported to find an appropriate care alternative. If the needs of a resident changes and they are no longer suitable for the service offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CSM. 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>On admission, residents of Flaxmore are initially assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, oral health, behaviour, continence, social and activities, nutritional screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data (e.g., the Abbie pain assessment), occurs every six months or more frequently as a resident's changing condition requires.</p> <p>In all files reviewed, initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments were completed within three weeks of admission and at least six monthly unless the resident's condition changed. Interviews, documentation and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when needed.</p> <p>All residents have current interRAI assessments completed by one of four trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the individualised 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 the care plans reviewed.</p> <p>In files reviewed, all components of care planning were in partnership with the resident, family and the multidisciplinary team. Plans identified triggers that were likely to impact on residents, and planning was based around reducing the triggers where possible. A resident, who gets distressed when their clothes are taken to the laundry, has a plan that includes clothes being laundered and returned promptly. A resident on warfarin, who</p>

		<p>refuses regular blood tests to monitor warfarin levels, has a plan in place to manage the resident's risk within the constraints of not being subjected to regular blood tests. A resident admitted with weight loss, and refuses meal supplements, had additional nutritional support added, and the resident is increasing in weight. Residents with a change in behaviour are immediately assessed for pain. Evidence was sighted of improved behaviours and a reduction in the use of antipsychotic medication when pain has been managed effectively.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care to residents was consistent with their individualised needs, goals and the plan of care (refer criterion 1.3.5). The attention to meeting a diverse range of resident's individualised needs was evident. Changes in residents' behaviour was promptly responded to, to identify the cause, address it and minimise the level of discomfort for the resident. Weight loss was attended to immediately, with consideration given to identifying a cause, including an oral assessment, in addition to ensuring staff focus on enabling the resident increased opportunity to have their nutritional needs met.</p> <p>The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>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 is provided by two trained diversional therapists, seven days a week.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. The residents "My Life" profile is developed and includes photos of events that the residents have been involved in. Activities assessments are used to formulate an individualised activity plan and an activities programme that is meaningful to the resident. The resident's activity plans are reviewed every three months and as part of the formal six-monthly care plan review.</p> <p>An initiative implemented by the diversional therapists, to assist new residents to settle in to Flaxmore, is an area identified as one of continuous improvement.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, small group activities and regular events are offered. Examples included riding for the</p>

		<p>disabled (two of the residents used to be jockeys), baking, dog therapy, peeling potatoes, neighbourhood walks, van outings, church services, target golf, visits to the 'men's' shed', quizzes, and gardening. Younger residents at Flaxmore were supported to access community initiatives with a support person.</p> <p>The activities programme is discussed at the minuted residents' and family meetings and indicated residents and family input is sought and responded to. Families interviewed confirmed the programme meets the residents' needs.</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 at Flaxmore is continually evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed were sighted for behaviour management, infections, pain, weight loss, and wound care. Progress was evaluated as clinically indicated and according to the degree of risk noted during the assessment process. 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 main medical provider, residents/families may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, NP or CSM sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the CSM or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. A change in the external company contracted to supply and manage chemicals and cleaning products has occurred within the past year and the company has provided relevant training for staff. Three spill kits are stored throughout the facility. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event</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>occur.</p> <p>A set of three rubbish skips for the management of general rubbish, plastics, cardboard/paper and food waste, which are removed and replaced by an external contractor, are in place at the rear of the facility. Potentially infectious waste is double bagged prior to disposal in general waste.</p> <p>There is provision and availability of protective clothing and equipment including gloves, masks, face shields, goggles and plastic aprons. Staff were observed using these. Hand sanitiser was in dispensers strategically positioned throughout the facility to ensure the safety of the residents with dementia.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness with an expiry date of 5 July 2019. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Any broken equipment or identified hazard is reported to a maintenance person who addresses the issue in a timely manner. A person was in a designated position for maintenance; however, this work is currently being undertaken by a contractor using relevant forms and recording systems. The testing and tagging of electrical equipment and the calibration of bio medical equipment was current; as confirmed in documentation reviewed and observation of the environment. Checks of mechanical equipment including wheelchairs and hoists for example are undertaken according to the schedule detailed in policy documents. Efforts are made to ensure the environment is hazard free and residents are safe.</p> <p>External areas are tidy, safely maintained and are appropriate to the resident group and setting. Quality improvement projects related to two specific external areas have been implemented and a continuous improvement allocated for this criterion. These involved the laying of a path/walking track, erection of a soft fence and the development of a sensory garden. Evaluations inform how these projects have enhanced the lives of residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a mix of ensembles, separate shared toilet and hand basin units and separate shared toilets and showers. Toilets are appropriately pictorially labelled and have a sliding notification plate informing if it is occupied or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. The clinical services manager described a quality improvement project undertaken in one wing in which the configuration of the toilets has enabled the residents to see the toilet as soon as they open the door. Results showed that this has resulted in improved compliance with use of the toilet and a reduction in continence problems.</p>

receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed alongside a 'My Life' profile. Each person's door has something pertinent to their pat displayed on it to enable easier identification for them. Staff reported the adequacy of bedrooms and family members expressed appreciation at having the opportunity to contribute to decoration of their relative's room.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities as they choose. The dining and lounge areas are spacious and enable easy access for residents and staff. There are larger lounges in each wing with dining areas alongside in two of the three wings. One wing has a separate dining area. All communal areas garden outlooks and enable residents to have external access at any time. Residents can access other areas for privacy, if required and may choose to have their meals in their room if this makes their life easier. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	PA Low	<p>Laundry is undertaken on-site in a dedicated laundry. A mix of care staff and dedicated laundry staff undertake laundry duties and an interview with a person who frequently undertakes these duties occurred. This person demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. An organised system for returning residents' laundry was witnessed.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. The company that provides the chemicals has provided all staff, especially the laundry and kitchen staff with appropriate training.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme, informal family conversations and feedback processes such as resident/family meetings. Schedules for both services are available. Internal audit results report on the strong unpleasant odour of urine throughout the Teal and Maitai wings and an action plan has been developed. The cleaning staff have diligently made all efforts to prevent this worsening and to address the problem but to date have been unsuccessful. A corrective action has been raised</p>

		to ensure the carpet replacement occurs as soon as possible.
<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 available. Staff confirmed their awareness of these, who is responsible for different levels of response and of the different levels of emergency. 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 current fire evacuation plan was approved by the New Zealand Fire Service on 8 September 2006. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being November 2018. The orientation programme includes fire and security training.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, torches, blankets, mobile phones and a gas BBQ with additional gas bottles in storage were sighted and meet the requirements for full occupancy. The quantity of bottled water stored in the garage for use in an emergency is consistent with the latest information from the local council. All emergency equipment and supplies are checked monthly and evidence of this was sighted.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis. Staff reported that there is minimal use of call bells by this group of residents; however, they noted that they receive ongoing reminders about the importance of responding to them. Families reported staff respond promptly to call bells when they are used.</p> <p>Appropriate security arrangements are in place. External windows in vulnerable areas of the facility have security latches in situ. Doors and windows are locked at a predetermined time and both the afternoon and night shift staff sign off building security checks each day/night. All residents are accounted for at allocated timeframes throughout the day.</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. The monitoring of indoor temperatures has been occurring weekly; however, with stable appropriate temperatures recorded, this is changing to monthly. Residents' rooms have natural light and opening external windows and in communal dining and lounge areas glass doors open onto patio and garden areas.</p> <p>Ceiling heating has been installed in the residents' rooms and in the hallways. Two heat pumps for air conditioning are in lounge areas and another is about to be installed in the Redwood wing lounge. Evidence of this about to occur was viewed. Fans for cooling purposes are available. Areas were well ventilated throughout the audit and families and staff confirmed the facilities are maintained at a comfortable temperature.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Flaxmore provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the CSM and the infection control nurse (ICN). The infection control programme and manual has been reviewed within the last year.</p> <p>The RN with input from the CSM is the designated ICN, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CSM and tabled at the quality/risk meeting. Infection control statistics are entered in the organisation's electronic database. The organisation's national quality and risk manager is informed of any IPC concerns.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN has appropriate skills, knowledge and qualifications for the role. The ICN has undertaken post graduate training in infection prevention and control as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available. The ICN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICN confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are</p>	FA	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

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>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICN. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained.</p> <p>When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in eye infections.</p> <p>Education with residents is generally on a one-to-one basis and includes family members.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICN and CSM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is</p>	FA	<p>Organisational policies and procedures on restraint minimisation and safe practice, last reviewed October 2018, 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/clinical services manager position description notes the person is to provide support and oversight for any enabler and restraint management in the facility.</p>

<p>actively minimised.</p>		<p>On the day of audit, there were no restraints or enablers in use. The restraint coordinator was very clear that there is a no restraint policy in this facility and informed that they promote their service as a no restraint environment. The facility has not needed to use any form of restraint for around three years, therefore there has not been any use of restraint within the timeframe of the current owner. This information was confirmed by staff during a group interview. Any restraint or enabler requires approval from a national HLL restraint approval group and with no restraint having been used in recent times there is no current restraint register. During interview, the restraint coordinator demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>Staff have been updated on the review of the restraint management policy documentation and additional staff education on the topic has been provided to ensure staff understand the related issues, should they ever need to know. The management of behaviours that challenge is also an ongoing in-service education topic.</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)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	An annual performance appraisal process is in place for all staff with the facility manager and the clinical services manager responsible for the reviews of relevant categories of staff. The recording system includes details of the due date. A quality improvement process was implemented in October 2018 when it was identified that not all staff performance appraisals were up to date. Although progress has been made, there were still twelve of the 45 staff on that list whose appraisals were outstanding because they were still incomplete or not completed. The record showed that of those overdue, all had been given their appraisal document to work on; however, these have either not been returned or not yet had an appointment with the respective manager. The record also showed that appraisals due as far back as April and May 2018 are on the overdue list or have just been completed. It was also suggested the recording system is altered to more easily reflect the status of each staff person's appraisal.	There is an annual performance appraisal system in place. At the time of audit, not all staff had a current completed annual performance appraisal.	All staff have completed each stage of their annual performance appraisal within the last 12 months. 180 days

<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>PA Low</p>	<p>The need for carpets in the Redwood wing to be replaced was raised for corrective action at the provisional audit and there was evidence that the carpets in this wing and in the reception area had been lifted and replaced with vinyl. A range of internal monitoring processes including complaints from family members, family feedback processes, internal audits and general feedback note that the odour from stale urine in carpets in the remaining wings of Maitai and Teal is also an issue of concern. The team were aware of the problem and an action plan has been implemented. Quotes for these carpets to be replaced with vinyl were sighted and there was evidence of efforts made to deep clean with repeated carpet shampooing occurring. The tradespeople visited during the audit. A corrective action has been raised to address this ongoing issue.</p>	<p>Despite regular cleaning and shampooing of carpeted floor surfaces, internal audits used to monitor cleaning processes, the complaints process, family feedback and auditor observations, note the persistent and strong odour of urine in the Maitai Wing and the Teal Wing.</p>	<p>Carpets in the Maitai Wing and the Teal wing are replaced, and appropriate processes undertaken, to remove the unpleasant odours in these areas.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Multiple clinical indicators have been identified and incidences of these, or progress with these, is reported to the support office of Heritage Lifecare (BPA) Limited on a monthly basis. These vary from resident related falls, medication errors, pressure injuries, infections and any restraint use, for example. The clinical services manager at Flaxmore is not only actively collating and analysing this data but is also implementing action plans to address the issues, for which evaluations and reviews are showing significant improvements in many areas for individuals and/or groups of residents, depending on the emergent trend or issue. The clinical services manager informed that she undertakes daily reviews of the clinical indicators and at the end of the month shows the analyses of the data to all staff and discusses it with them. This was confirmed by staff during interview. Interested staff are enthusiastically supporting the clinical services manager and suggested improvements in documented action plans are implemented. Examples include the change of configuration in the toilets/bathrooms in one area, which has resulted in improved continence, and the multiple falls that were identified as occurring between 1pm and 4pm have significantly reduced since the introduction of an afternoon nap for these residents. Pain assessments have become routine for residents demonstrating unsettled behaviours after a person who was being prescribed increasing doses of medicines to reduce their aggression and withdrawal was found to be in pain. Once the pain was addressed, all such signs of aggression have gone. Other similar examples were reported. Another person was found to have weight loss and an increasing disinterest in food.	Implementation of changes following the analysis and evaluation of quality improvement data and information, especially the data linked with clinical services, is demonstrating continuous quality improvement. Quality and staff meeting minutes

		Following removal of their teeth the person's overall health has improved and weight gain has occurred. This has contributed to the service provider promoting appropriate oral care for all residents and making significant attempts for the community and the DHB dentists to support them in their campaign on this. Overall, the many efforts being made to improve the health and wellbeing of residents as a result of the analysis of clinical indicators and evaluation of implemented actions is demonstrating continuous improvement.	described multiple projects and progress with action plans and subsequent evaluations and reviews that are aimed at improving the lives of the residents, and/or reducing risks to them.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Over the last six months, an initiative was implemented at Flaxmore to trial the use of weighted pet therapy, when residents are admitted and exhibiting signs of increased distress and agitation related to the move to Flaxmore. Three residents were initially identified by observations, as being able to benefit from this intervention. Staff observed a change in the resident's body language when the weighted animal was put in their laps. Residents displayed a sense of attachment, companionship and comfort and were less distressed. The families were approached to purchase each resident their own animal. Two residents have become completely attached to their animal. The third resident has not got their own animal and is reliant on staff providing the resident with a facility animal. The evaluation of the initiative evidences an improvement in residents' distress on admission and ongoing use of weighted animals. The success of this initiative is supported by testimonials from families.	To help new residents feel less distressed when admitted to Flaxmore, weighted pet therapy is used and evidenced to make the move into a secure unit less distressful.
Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	CI	Several projects have been completed with the purpose of improving the external environment for residents. In one instance it was suggested that residents needed an outdoor area that could stimulate them and with which they could engage in outdoor tasks. Following research, a quality improvement initiative was developed around building a sensory garden. As per an action plan, a previous garden with plants, such as roses was redeveloped, safe and edible plants were identified and planted, signs providing information about the plants were made, fairy lights installed, garden ornaments positioned and a newsletter distributed to remind family members to take residents out for a walk in the garden for a chat about the plants and to taste the fruit and vegetables. The	Evaluations of three planned resident-focused projects that involved the re-landscaping of different areas of the external

		<p>evaluation report described how residents and family members have been witnessed increasingly using the area. Residents have showed enjoyment and pride as they plant, weed and watch the plants grow and eat the produce. Further measures of success have included the number of plants left in the garden compared with previous plantings, observations of residents choosing to go out and just sit or wander around and of them fiddling in the garden with seashells and picking and holding bunches of flowers and herbs (also observed during the audit). Family members have been observed interacting with their relative about aspects of the garden and have made positive comments.</p> <p>The service provider also recognised that residents from a specific wing were unsettled, pacing and trying to get out in a specific area of the garden where they could see people coming and going. A plan was developed on a quality action plan and a decision was made to enclose the garden in a friendly way. A brush fence was erected, and the residents have become calmer, they are no longer distressed watching family leave, there is no more pacing or efforts to get through the fence. Family members who were initially unsure about a higher fence have noted the difference and feedback has been positive.</p> <p>A third initiative involved the planned laying of a concrete pathway through various types of garden and foliage areas. The path links from one doorway into another whilst still being in an enclosed area. This is safe and is sensor lit for use at night if a person chooses. A formal opening involving residents and the community was undertaken. Evaluations inform how residents no longer hover around doorways, there is reduced calling out from frustration and many have increased their mobility by walking around the path.</p>	<p>environment describe how the agitation of some residents has subsequently been reduced, increased mobilisation has occurred, and some are responding positively to different sensory stimuli.</p>
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End of the report.