# Heritage Lifecare (BPA) Limited - Waterlea Rest 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Heritage Lifecare (BPA) Limited

**Premises audited:** Waterlea Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 7 February 2019 End date: 8 February 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:** 56

# 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 |
|  | 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

Waterlea Lifecare provides rest home and dementia care for up to 61 residents. The service is operated by Heritage Lifecare (BPA) Limited and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

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

This audit has resulted in a continuous improvement in relation to staff training. There were no areas identified as requiring improvement.

## Consumer rights

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| --- | --- | --- |
| 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. |

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents of Waterlea Lifecare and their family members/whanau. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Waterlea Lifecare provides services 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.

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

Information about the complaints process is provided to each resident and their family members at the time of admission. The facility manager and the clinical services manager are responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

## Organisational management

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

Heritage Lifecare (BPA) Limited is the governing body and is responsible for the service provided at this facility. A business plan and a quality and risk management plan are documented and include the scope, direction, goals and values of the organisation. Systems are in place for monitoring the services provided, including regular weekly reporting by the facility manager to the governing body as well as monthly reporting of clinical indicators to the governing body by the clinical services manager. The facility is managed by an experienced and suitably qualified manager.

A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and results are reported to the quality and staff meetings, with discussion of trends and follow up where necessary. Meeting minutes, graphs of clinical indicators and benchmarking results are displayed. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A suite of policies and procedures cover the necessary areas, were current and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme ensure staff are competent to undertake their role. A systematic approach to identify, plan, facilitate and record ongoing training supports safe service delivery. Annual individual staff performance reviews are completed. Registered nurses are encouraged to undertake external professional development opportunities relevant to their role.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. Registered nurses are on a roster to attend to on-call out of hours and the facility manager is also available.

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

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| --- | --- | --- |
| 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. |

Waterlea Lifecare 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, up to date care plans and the care manager’s report guides 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 expected 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 activity assistants and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

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

## Safe and appropriate environment

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

The facility has been purpose built. There are single rooms in the rest home and in the dementia service, as well as a wing of 13 apartments with ensuite bathrooms. All are of adequate size to provide personal care.

All building and plant comply with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite, with systems monitored to evaluate effectiveness of both laundry and cleaning processes.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to an emergency power source is available. The call bell system is monitored by the facility manager to ensure residents receive a timely response to call bells. Appropriate security systems are in place.

## Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers or restraints in use at the time of audit and it is the philosophy of the organisation that such interventions are not used unless as a last resort. Staff confirmed that enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and thereafter every two years, including all required aspects of restraint and enabler use.

## Infection prevention and control

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

The infection prevention and control programme, led by an experienced and appropriately trained infection control officer, 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 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 92 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | Waterlea Lifecare (Waterlea) 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 choice and maintained 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 understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, outings, invasive procedures and collection of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s file. All residents in the secure unit have either activated Enduring Power of Attorneys (EPOAs) in place or have evidence that papers have been lodged to have a protection of personal and property rights (PPPR) person for the resident appointed. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff were aware of how to access the Advocacy Service. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | An organisational policy on the management of complaints and concerns meets the requirements of Right 10 of the Code. The facility manager reported that people are informed about the complaints process when they first look at the facility. On admission, the facility manager and the clinical services manager also jointly described the complaints, concerns and compliments process and the associated forms to new residents and their family and showed them where they are available at the reception desk. Despite this, an internal audit revealed that respondents were unsure where the suggestions box is placed, and this is being addressed.  The complaints register reviewed showed that five complaints had been received during 2018 and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Most complaints are followed through by the facility manager, with assistance from the clinical services manager when relevant. Action plans reviewed show any required follow up and improvements have been made where possible.  All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed at reception and in corridors throughout the facility. Brochures on the advocacy services, how to make a complaint and feedback forms are available at the front entrance. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and family members confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families and the general practitioner (GP). All residents have a private room.  Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each care plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There was a resident in Waterlea at the time of audit who identified as Māori. Documentation, interviews and observation verified staff supported the resident 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 a current Māori health plan developed at organisational level with input from cultural advisers. The facility has access to clinical support from a local Maori health provider if assistance is required to meet the needs of Maori residents. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents and family members 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 all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met, and this supported that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A GP and nurse practitioner (NP) also expressed satisfaction with the standard of services provided to residents.  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. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Waterlea encourages and promotes good practice using up to date evidence-based policies, input from external specialist services and allied health professionals, for example, a wound care specialist, community dieticians, services for older persons mental health, a community mental health nurse, respiratory district nurse, palliative care nurse and the NP. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support to attend external education sessions through the Nelson Marlborough District Health Board (NMDHB), access on line learning sites, and through in-service education sessions (refer criterion 1.2.7.5).  Other examples of good practice observed during the audit included the commitment to ensuring care plans were always reflective of the residents’ changing needs and successful management of chronic wounds. The fostering of a collaborative approach by the management team at Waterlea acknowledges and values the work of all staff, when enabling residents to receive care of the highest level. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members of Waterlea stated they were kept well informed about any changes to their own or their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services can be accessed via Aged Concern when required. Staff reported interpreter services have rarely been required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | An overarching Heritage Lifecare (BPA) Limited strategic plan that was reviewed in 2018 is available. A site-specific business plan, as required for each Heritage Lifecare facility, which covered the purpose, scope, direction and goals of the facility was also provided. Values of the organisation are described in ‘the Heritage Way’, a document that all staff are required to read and sign. Annual operational and long-term objectives were described in the business plan as were action plans. Weekly operations reports are provided to the support office, as are monthly reports on clinical indicators and key performance indicators, which enables the support office to monitor performance including around issues of occupancy, staffing, financial performance, and emerging risks and issues.  The service is managed by a suitably qualified and experienced facility manager who has had almost thirty years in management roles within the aged care sector and has managed Waterlea since 2009. A description of attendance at various courses on leadership and management was provided. The facility manager continues to undertake professional development opportunities, participate in quarterly meetings with local district health board (DHB) and needs assessment teams, attend conferences and maintain links with other managers within the aged care sector. Knowledge of the sector, regulatory and reporting requirements was confirmed.  The service provider holds contracts with the local DHB to provide rest home and dementia care (rest home level) under the Aged Related Residential Care Agreement (ARRC). It also holds a contract with the Ministry of Health for Young Persons with Disabilities (YPD), although no one at the facility was on this contract during the audit. On the first day of audit, there were 39 people receiving rest home level care for which 42 beds are available and 17 receiving dementia care for which 19 beds are available. Two of the dementia service residents are under 65 years and come under the Long Tern Chronic Health Conditions contract. Within the rest home and included in the numbers above, there are 13 apartments that have larger rooms and ensuites. The residents pay a weekly rental for these rooms. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the facility manager, the clinical services manager carries out all the required duties under delegated authority. The clinical services manager is an experienced registered nurse who has previously worked as a unit coordinator in other facilities. Additional support is available from the Heritage Lifecare (BPA) Limited support office and from the management team at a nearby rest home with whom they have close associations.  During absences of the clinical services manager, there are other registered nurses in the team to assist. Clinical expertise is also available from another service provider and from clinical staff at the Heritage Lifecare (BPA) Limited support office. All are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported that there is excellent access to clinical advice and support, and they have been taught to contact emergency services if they are unsure. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a quality and risk system that is being implemented according to a comprehensive quality and risk plan and reflects the principles of continuous improvement. This plan includes terms of reference for the quality management committee, a set of quality goals and quality indicators. It describes how key elements of the various aspects of the quality and risk system are to be implemented. Examples of monitoring processes include the management and feedback about complaints, incidents, internal audit activities, review of clinical indicators and outcomes including for pressure injuries, wounds and infections, surveys for resident, family and staff satisfaction and the monitoring of health and safety issues and identified risks.  Monthly quality management meetings, which include health and safety and infection control are occurring. Meeting minutes from these were reviewed and confirmed adequate and regular reviews and discussion on quality and risk matters are occurring. Staff receive updates on the relevant aspects emerging from the quality management meetings at monthly staff meetings, which are minuted. Analysis of each aspect was evident and relevant corrective actions and quality improvements implemented as indicated. Records reviewed included several quality improvement initiatives that had been followed through to evaluation and evidence that corrective actions had been completed and closed out. Staff overall participate in the internal audit programme, which is comprehensive and maintained according to the timetable. Resident and family surveys are completed annually with the most recent undertaken in November 2018. The last survey showed overall satisfaction with one or two comments on specific issues such as laundry or food, rather than identifiable themes.  Policies reviewed cover all necessary aspects of the service and contractual requirements and were current. There are appropriate references to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff are updated on new policies or changes to policies through staff meetings. Copies of new and amended policy documents are placed in the staff room and staff are required to sign they have read them.  The facility manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register shows consistent review and updating of risks, risk plans and the addition of new risks. The manager is aware of and attended training in the Health and Safety at Work Act (2015) requirements and has implemented requirements. A hazard register is regularly updated and staff informed they are expected to contribute to this if they identify any issues of concern. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Policy and procedures describe essential notification reporting requirements and adverse event reporting and management processes. The facility manager was aware of the need to report incidences of pressure injuries, infection outbreaks, at risk residents, police involvement, staff shortages and unexpected deaths, for example, to relevant authorities as well as to the Heritage Lifecare (BPA) limited support office. There have been no significant events requiring essential notification since the last audit.  Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is collated, analysed for trends and reported to the monthly quality and risk management meetings, to the support office and at staff meetings. An example of a documented quality improvement initiative aimed at reducing the incidence of falls was reviewed and showed a 27% decrease in falls incidence as a result (refer continuous improvement in 1.2.7.5). |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are systematically maintained. Annual practising certificates are reviewed annually for all health professionals associated with the residents of the service and copies of these are retained by the facility manager. All sighted were current.  There are a sufficient number of trained and competent registered nurses who are maintaining their annual competency requirements to be able to undertake interRAI assessments. Four registered nurses have a current interRAI assessment competency with a fifth having commenced their training.  Staff orientation includes all necessary components relevant to the role. Staff provided favourable reports about the orientation process now available for new staff and noted it is individualised according to a person’s previous experience. The process includes support from a ‘buddy’ through their initial orientation period. Staff records reviewed showed documentation of completed orientation and evidence that the facility manager is completing a performance review for new staff after a three-month period. Annual performance appraisals were current for all other staff.  Organisational mandatory staff training requirements are defined and scheduled to occur over the course of the year. A month by month training calendar for 2018 - 2019 was evident and includes additional ‘special interest’ topics, most of which have been in response to identified quality improvements needed. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. Staff working in the dementia care area have either completed, or are enrolled in the required education, although all staff have completed a basic overview of managing residents with dementia. Education records reviewed demonstrated completion of the different types of required training, which has been enhanced by one on one follow-up for non-attendees and additional courses provided if attendance is too low. Commitment to ongoing staff education was evident and the information available from a related quality improvement project suggested that the additional emphasis on training has been a significant contributing factor to the 27% reduction in falls over less than a year in this facility. A continuous improvement has been allocated for this criterion. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisation wide documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. This is currently under review.  Meantime Waterlea is using a monitoring tool to guide staff allocations on the roster and adjusts staffing levels to meet the changing needs of residents. A ‘flexi shift’ on both morning and afternoon shifts is lengthened, or withdrawn, as indicated and additional staff have been rostered in the dementia service when this was required to meet one on one support needs of a resident until a re-assessment could be completed. The facility manager is on call seven days a week and is relieved by the clinical services manager when on leave. The clinical services manager is on-call Monday to Friday and one of the other registered nurses takes the on-call phone during weekends and when the clinical services manager is on leave.  Unplanned absences and any needs for additional staff are filled by current staff who choose to pick up extra shifts when they are available. No agency staff, or people unfamiliar with the residents, are used in this facility and the staff and manager confirmed that healthcare assistants never work short. A laundry person or housekeeper would be withdrawn before this happened. Three casual staff are available.  The minimum number of staff is provided during the night shift. This consists of two healthcare assistants, one of whom is allocated to the dementia service and one to the rest home. A household/carer works between the dementia service and the rest home as required. Each shift has a team leader allocated on the roster. In addition to the clinical services manager, a registered nurse who does not take a resident workload, is on duty every morning shift with an enrolled nurse or a very senior caregiver on afternoon shifts.  Healthcare assistants reported during interview that adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a six-week roster cycle sample during this audit confirmed adequate staff cover has been provided and is planned. All registered nurses, enrolled nurses and senior caregivers undertake first aid training/cardio-pulmonary resuscitation every two years; therefore, all shifts are covered by at least one staff member with a current first aid certificate. An activities coordinator is in the rest home, and one in the dementia service, every day on seven days a week. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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.  Archived records are held securely either onsite where the resident is still a resident, or offsite if the resident is no longer residing at Waterlea. All records are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.  Electronic medication records are stored in a secure portal. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Residents requiring care in the secure unit require placement approval by specialist services, an activated EPOA or a PPPR application before the courts.  Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) and the clinical services manager (CSM). They are also provided with written information about the service and the admission process.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the NMDHB ‘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. Residents are accompanied by family members where possible. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. 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.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted included the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.  There was one resident who self-administers medications at Waterlea, at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.  Medication errors are reported to the RN and CSM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.  Standing orders are not used. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been planned by a qualified dietitian in November 2018.  A food control plan is in place and has been registered with the Marlborough District Council. A verification audit of the food control plan was undertaken by the council 19-September-2018. No areas requiring corrective action were identified.  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.  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.  Residents in the secure unit have access to food at any time of the day or night.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whanau /family. There is a clause in the access agreement related to when a resident’s placement can be terminated. Examples of this occurring were discussed with the CSM and FM. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission, residents of Waterlea are initially assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, depression scale and a behaviour assessment, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require. Behaviour assessments for residents with evidence of behaviours that challenge, had ongoing reviews of assessments based on behaviour monitoring documentation.  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 every six months 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 a resident has increasing or changing need levels.   All residents had current interRAI assessments completed which are used to inform the care plan. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed. Care plans of residents suffering from dementia had twenty-four-hour activity plans in place and behavioural management plans that included triggers and related interventions. Evidence is sighted of ongoing reviews of the plan.  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. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care to residents of Waterlea was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. A resident with a history of chronic wounds and identified as requiring palliative management, has had one wound healed and one substantially improved. Residents in the secure unit were observed to be well dressed, relaxed and happy. Staff were observed to respond to all residents in a gentle and respectful manner when requesting resident’s co-operation in attending to resident’s needs. 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. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by two activities assistant, with oversight from a qualified diversional therapist. A third activities assistant is starting in a week. Activities are provided seven days a week in both the rest home and the secure unit.  A social assessment and history are 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. Residents in the secure unit, and residents in the rest home who have some degree of dementia, activity plans in place that addresses the residents’ twenty-four-hour needs. The resident’s activity needs are evaluated regularly and as part of the formal six-monthly care plan review. One to one activities are provided for residents under sixty five years, these activities are specifically focussed on each resident.  The planned monthly activities programme, operating in both areas of the facility operates seven days a week. The programmes sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples include daily exercise programmes, walking groups, pet therapy, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the minuted residents’ meetings and indicated residents’ input is sought and responded to. Resident and family satisfaction surveys demonstrated a high degree of satisfaction with the activities being provided at Waterlea. Any areas of dissatisfaction are used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  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 were consistently reviewed for new behavioural issues, infections, pain and weight loss. Progress is evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Behavioural plans were reviewed on an ongoing basis in line with behaviour monitoring records. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, 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 older persons’ mental health services. Referrals are followed up on a regular basis by the RN 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. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances were in place. Infection control documentation includes a waste management section detailing procedures for management and disposal of potentially infectious waste. A contractor provides rubbish skips and empties these two to three times a week. Food waste is double bagged and placed in the general waste. Metals, plastics and cardboard are recycled.  The doors to the areas storing chemicals were secured with key pad locks and containers labelled. 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. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.  There is provision and availability of protective clothing and equipment and staff were observed using this, including gloves, plastic aprons, and gumboots with personal socks. A cleaner consistently uses goggles. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness issued 1 July 2018 is publicly displayed. Residents are able to mobilise around the facility easily.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment (last completed 28 September 2018) and calibration of bio medical equipment (undertaken 18 July 2018) have occurred. An ongoing seventeen-year problem with hot water temperatures, which sees most as completely normal and others as showing inconsistent variations between the expected temperature range, too hot or too cool has been further investigated and new actions taken. Correspondence from a property asset manager at Heritage Lifecare (BPA) Limited confirmed yet another suggested action is in progress.  External garden and patio areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Residents interviewed confirmed that any maintenance is attended to promptly and that they enjoy the environment at Waterlea. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There is a mix of toilet, showers and bathing facilities. Rooms in the Magnolia wing have ensuites and all other residents’ rooms throughout the remainder of the facility, including the dementia service have a toilet and handbasin.  Five toilets and two showers are in the Forget-Me-Not (dementia service) wing, all with clear pictures on the doors. The lavender wing has two showers and one toilet, plus two rooms have their own shower. Columbine wing has a shower and toilet facility.  There are adequate numbers of accessible bathrooms and toilets throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence. Staff confirmed the toilet and shower facilities are of sufficient size to provide residents with the required assistance. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation with larger rooms in the Magnolia wing and in Forget-Me-Not (dementia service). Rooms, including in the dementia service, are personalised with furnishings, photos and other personal items displayed.  There is sufficient room to store mobility aids walking frames and wheel chairs, so long as this is done tidily. Staff and residents reported the adequacy of bedrooms with staff stating that they could manoeuvre a hoist in each if this was needed. Mobility scooters are stored in designated areas and do not impede walkways or create a hazard for mobile residents. Family members commented on the ‘homely’ environment and stated the rooms were of a ‘good’ size. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. There are three large size dining rooms, one in Magnolia, one in the main rest home and one in the Forget-Me-Not wing. Spacious lounge areas are complemented by smaller lounges in Magnolia and Forget-Me-Not and nooks in the Columbine and Forget-Me-Not areas. Residents can access these smaller lounges and nooks areas for privacy, if required.  Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely. Residents may bring some of their own furniture from home when they are admitted. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is undertaken on site in a dedicated laundry. Resident’s personal items are laundered on site, or by family members if requested. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently mostly washed by four cleaning/laundry staff, although night staff will assist when required. Staff interviewed were familiar with the laundry processes, knew about the importance of the dirty/clean flow and how to manage soiled linen.  A cleaning staff person informed they have undertaken chemical safety training and evidence of this was sighted in staff training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Some healthcare assistants and kitchen hands will take on cleaning duties when required. Cleaning and laundry processes are monitored through the internal audit programme with the most recent being November 2018. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency management, preparation and response are known to staff. The current fire evacuation plan was approved by the New Zealand Fire Service on 15 August 2003. A trial evacuation takes place six-monthly with the most recent being on 22 August 2018 and 18 February 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  An (infection) outbreak kit is available and the contents checked according to the internal audit schedule. Likewise, for emergency supplies in a civil defence kit. The facility manager provided evidence of a recent review of the emergency plan and of the emergency kit by a person from the local civil defence unit who provided a staff education session. Updated disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. Supplies have also been adjusted according to the latest recommendations provided and a new storage system is now in use. 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 full occupancy. In addition to the hot water cylinders, water storage tanks are located in the ceiling and additional water is in plastic bottles. Emergency lighting is regularly tested.  An electronic call bell system that enables the manager to print off response times for monitoring purposes is installed. Call buzzers alert staff via their pagers to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. There have been no complaints about slow responses to call bells filed.  Appropriate security arrangements are in place. Doors and windows are locked by staff at a predetermined time and it is on staff task lists to undertake security checks of the facility at specific times with attention paid to the external doors of the bedrooms in the Magnolia wing. Security stays are on all windows and external sensor lights are installed. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas have opening external windows. There are some in the Magnolia wing that have doors that open onto outside garden or small patio areas.  Two forms of underfloor heating are in place and this is complemented by ceiling mounted electric heaters in areas where the underfloor heating systems are no longer functioning efficiently. Monthly monitoring of room temperatures and of communal areas is undertaken with records sighted. Fan electric heaters are in bathrooms. A heat pump is in communal areas. Windows were open and fans in operation to improve ventilation on the day of audit. Residents confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service 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. The infection control programme and manual are reviewed annually.  The CSM is the designated infection control officer whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the FM, the organisation’s quality clinical team and tabled at the facility’s quality/risk meeting. Infection control statistics are entered in the organisation’s electronic database and benchmarked within the organisation’s other facilities. The organisation’s quality clinical team is informed of any IPC concern.  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. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control officer (ICO) has appropriate skills, knowledge and qualifications for the role, having undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established networks with the microbiologist at South Canterbury Laboratory guide the ICO with any required IC advice. The ICO has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICO confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, 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. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | 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 ICO. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a Norovirus outbreak in April 2018.  Education with residents, where able, 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. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, 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.  The ICO and FM 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. Data is benchmarked internally within the group’s other aged care providers. The incidence of infections at Waterlea are evidenced to be low compared to the benchmarking data. Classification of infections for data collection at Waterlea is based on the McGreer definition.  Evidence was sighted of documentation including review and analysis of the Norovirus outbreak in April 2018, with corrective actions documented and attended to. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical services manager is currently undertaking the role of restraint coordinator who is currently on leave, and provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her/his role and responsibilities.  On the day of audit, there were no restraints or enablers in use at this facility and other than the finding at the last audit, when personal restraint was being used for one person, there has been no other restraint use. With no restraints having been used since the change of ownership, there was no restraint register. Reports in the quality and risk meeting minutes consistently confirmed they were not being used. Approximately six months ago, a person who is no longer in this service chose to use bedrails as an enabler and the restraint coordinator confirmed the person was competent and had consented.  Staff reported during interview that it is a restraint free environment and they described the differences between a restraint and an enabler. They also stated they receive training about restraints, enablers and their management during orientation, in the national certificate training as well as annually as in-service. This was evident in the staff training records. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
| --- |
| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| 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. | CI | In addition to the ongoing education programme, the facility manager and the clinical services manager have targeted staff education as a key approach to address areas identified as requiring improvement. There has been a tangible increase in staff attendance at in-service sessions and there has been good attendance at a diverse range of ‘toolbox talks’ on issues such as management of infections and diabetes. Education of staff was planned to address the shortcomings regarding restraint use that was identified at the provisional audit and all staff have since been updated on restraint and enabler use to ensure they have a good understanding and there is no repeat of the finding. A caregiver has spent several years upskilling as a moving and handling competency assessor and has earned obvious respect of her colleagues who are cooperating with her instructions. There are 13 healthcare assistants with level four national certificate and none with level three, out of 25 healthcare assistants.  The management-led passion for education has filtered to staff and there was evidence of excitement when the value of training was discussed during a staff meeting. During discussion, both the facility and clinical services managers attributed the 27% decrease in falls over 2018 to be the result of the focus on staff education. This strategy was used as a number of staff had already shown receptivity to learning, as described above. A quality improvement project plan demonstrated that education was a key aspect of the process, alongside physical changes such as the use of sensor mats, mapping of falls, decluttering, physiotherapy reviews, intentional sighting of frequent fallers, repeated monitoring and additional supervision. Ultimately, and the aspect that has earned the team a continuous improvement, an evaluation of the project identified additional staff knowledge, which increased their awareness and enabled them to actively co-operate with implementing the plan, as the primary reasons for this positive outcome for residents. | Staff attendance at in-service education sessions, the uptake of external training opportunities, the number and topics of toolbox talks aimed at addressing identified needs for quality improvements and the significant 27% reduction in the incidence of falls that the management team attribute to the type and frequency on related staff education is demonstrating continuous improvement. |

End of the report.