

Heritage Lifecare Limited - Palms Lifecare

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Heritage Lifecare Limited

Premises audited: Palms Lifecare

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

Dates of audit: Start date: 13 May 2019 End date: 14 May 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: 116

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
Yellow	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
Red	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

Heritage Lifecare Limited – Palms Lifecare provides care for up to 123 residents requiring rest home and hospital level medical and geriatric care.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board (DHB) . The audit process included the review of policies, procedures, residents’ and staff files, observations and interviews with residents, families, a general practitioner, management and staff. A new care home and village manager has been employed since the last audit (starting in February 2019). A new clinical services manager has been recruited but not yet commenced. A senior registered nurse is acting in the clinical services manager role in the interim. An additional unit coordinator has been employed so there is one in each of the three units.

There were ten areas requiring improvements from the previous Ministry of Health inspection in August 2018. Issues related to governance, needing a quality improvement process based on continuous improvement, reporting adverse events, staffing, the activities programme, evaluation of residents’ progress and heating have been addressed. The three issues related to assessment, care planning and staff performance appraisals remain a work in progress. In addition, there are two new areas identified as requiring improvement related to complaints management and staff handover processes.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Staff and management are adhering to the principles and practises of open disclosure. Access to interpreters and support for residents who have barriers to communication is provided.

The organisation has a known and effective complaints management system. Complaints and concerns are acknowledged in writing, investigated and the results of investigation are reported and shared as appropriate. These are logged on the organisation wide electronic system which is only accessible at this level by authorised people. The District Health Board, Ministry of Health and the Office of the Health and Disability Commissioner have been involved in complaint investigations since the previous certification audit. One such complaint is still in progress.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the care home and village.

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

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

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Processes are in place to ensure residents are assessed on admission, and an interim care plan developed. Systems are in place to facilitate the resident being reviewed by a general practitioner, within two days of admission and at least three monthly or sooner when clinically indicated. Care is changed to meet individual resident's needs, with input from other internal and external health professionals where applicable.

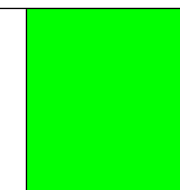
All applicable residents have interRAI assessments completed. Long term care plans are evaluated at least six monthly.

The service provides planned activities. Participation is voluntary. Records of participation are retained and monitored.

Two onsite kitchens provide and cater for residents' specific dietary needs, with likes and dislikes accommodated. The service has a four-week seasonal rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

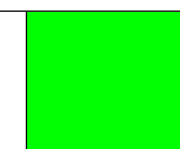
A safe medicine administration system was observed at the time of audit.

Safe and appropriate environment

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

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. Three enablers and two restraints were in use at the time of audit.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, with data analysed, trended, benchmarked within Heritage Lifecare Limited (HLL) and results reported back to staff and management in a timely manner.

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	13	0	0	5	0	0
Criteria	0	37	0	0	5	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Complaint and compliment forms are on display by the visitors sign in books and the complaint process is described in the residential agreement, but some residents and family members were either not informed or expressed reluctance to raise concerns (refer to the improvement required in criterion 1.1.13.1.)</p> <p>Since November 2018, complaints received are entered into the electronic information system by whomever receives the complaint. But the system does not alert the care home and village manager, who is responsible for complaints management and follow up, when a new complaint is entered. The data is logged chronologically by date, but identifying information about the complaint, for example, names of the people concerned, the nature of the issue and its progress depends on what information is entered in the first few lines. This poses a barrier to readily identifying and tracking individual events and requires improvement. The organisation has recognised this and is in the process of making changes.</p> <p>Review of the complaints system and register confirmed nine complaints have been received since August 2018. All of these have been acknowledged in writing, investigated and where possible agreement and resolution between the parties has been reached within acceptable timeframes. Counties Manukau DHB have been involved in investigating and monitoring the outcomes of various complaints since 2017. An unresolved complaint from February 2019 was escalated to the Office of the Health and Disability Commissioner, who are currently investigating the matter.</p>

		<p>The service is in receipt of an equal amount of compliments as it is complaints.</p> <p>Any service improvements or other follow up required as a result of complaints, are now documented in corrective action plans.</p> <p>Senior staff interviewed demonstrated a good understanding of the complaint process and what actions are required from them.</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 informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and the outcomes of regular and any urgent medical reviews. This was confirmed by the information reviewed in residents' records, complaint and incident reports. The service provider understands and endeavours to uphold the principles of open disclosure, which are described in policy. Evidence that information is provided in an earnest and open manner was sighted in letters to complainants and positive feedback from staff and residents about the new care home and village manager's communication style.</p> <p>Staff knew where and how to access interpreter services if needed to communicate with non-English speaking residents, but this has not been required recently. Staff said they most commonly find other methods for day to day communication or ask friends and family members to translate when needed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of reports to the operations and quality managers showed adequate information to monitor performance is reported including occupancy, complaints, incidents and any other emerging risks and issues.</p> <p>The care home and village manager (CH&VM) who has been in the role for 10 weeks, holds relevant qualifications and has many years' experience as a nurse and manager in age care facilities. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CH&VM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency by attending meetings with peers, funders and the people she reports to, receiving regular information about the sector and through attending professional development related to management and aged care.</p> <p>The service holds contracts with Counties Manukau District Health Board (CMDHB) for age residential care (ARC) rest home and hospital level care services, long term chronic health conditions (LTCHC) and short stay/respite. There is also a day programme contract which was not included in the scope of this audit. The facility has a maximum capacity of 123 certified beds, comprised of 21 rest home, 80 dual and 22 hospital beds. On the days of audit 59 hospital beds were occupied, which included one resident under 65 years of age and 57 rest home beds</p>

		<p>were occupied. This included two residents were receiving services under the LTCHC contract, one at rest home level and one at hospital level of care. There were no residents staying for respite/short stay care on the days of audit.</p> <p>The matters related to clinical governance identified by the Ministry of Health (MoH) inspection in August 2018, have been rectified through appointment of a third unit coordinator and a care home and village manager with clinical expertise in aged care. A new clinical services manager (CSM) has been recruited and is due to commence employment shortly. The person acting in the CSM role is the hospital unit coordinator/registered nurse with four years post graduate experience and has been employed by the service for two years.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of complaints, monthly audit activities and monitoring of outcomes, resident satisfaction surveys and the reporting and collation of incidents, pressure injuries, restraint and infections.</p> <p>The organisation, Heritage Lifecare Ltd (HLL), uses the same system for each of its 36 facilities to report their data which is then collated and used for benchmarking. Each care home and village manager receives a monthly quality indicator report that shows how their number of falls, pressure injuries, restraint, urinary tract infections and skin tears compared with other services and whether they are over or under the benchmarked target in each category. The CSM provides a monthly narrative report to the care home and village manager and the national quality team which discusses their statistics, possible reasons for trends and the planned or actual actions taken to remedy unwanted trends.</p> <p>Palms Lifecare also creates their own set of quality data, compared month by month that includes additional information on occupancy, non-clinical and clinical incidents, staff accidents/incidents, complaints and compliments, medication errors, the type and number of restraints/enablers, behavioural events, bruises, weight loss, and specific types of infections. These were observed on display in staff areas which staff said they were referred to. A range of meeting minutes reviewed confirmed these were discussed at weekly head of department meetings, the combined quality and risk/staff meetings and RN meetings. Staff reported their involvement in quality and risk management strategies through audit activities, quality projects and acting as representatives for health and safety. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. Results from the most recent September 2018 survey showed very little positive or negative variance from the previous year, with overall satisfaction sitting at 87.4%. The organisation is due to release a new format for satisfaction surveys, which will be used as soon as it is available to satisfy the DHB's recommendation that surveys are conducted every six months until the next certification audit in 2020.</p> <p>The care home and village manager attends regular meetings with residents from each area and produced written evidence of actions taken to address any issues raised at the meetings. A number of the residents interviewed said they felt reassured by the new manager's clear communication style and visible presence.</p>

		<p>Policies 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 were based on best practice and were current. 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. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Since November 2018, staff input all adverse and near miss events into the electronic database. A sample of incidents reviewed confirmed that unusual, or high severity coded (SAC 1 or 2) incidents are investigated. All incidents are reviewed by the unit coordinators and the CSM to determine cause and effect and what if any type of actions require follow-up. They also check who has been notified of the incident. Consequential actions are recorded in the resident's electronic progress notes. Adverse event data is collated, analysed and reported as described in standard 1.2.3.</p> <p>The records reveal an average 20 falls per month, the majority occurring in the hospital units and resulting in no injury. The overall rate of falls reported by Palms Lifecare is well below the organisation's benchmark of nine falls per 1,000 bed nights. There was one reported fracture in February 2019 and the notes related to this event reveal appropriate and timely actions were taken. The year to date data on skin tears and pressure injuries rates high in comparison to the organisations benchmarked data, for example eight pressure injuries, which includes one described as stage 4, (six of these were identified on admission). However it was discovered that ongoing rather than new pressure injuries were being reported. The extent to which all incidents are reviewed and monitored for completion is verified by the recorded discussions at RN meetings and interviews with the CSM and the care home and village manager. This was required in the corrective actions raised by the MoH and subsequent follow up by the DHB.</p> <p>The care home and village manager understands and adheres to the requirements for essential notification reporting, including for pressure injuries. The records showed nine notifications of significant events made to the Ministry of Health, since August 2018. These include breaches of security reports to the police, power outages, viral outbreak, a significant medication error and a stage four pressure injury. The DHB programme manager confirmed it was their preference that the service continued to over report all such incidents.</p>
<p>Standard 1.2.7: Human Resource Management</p>	PA Moderate	<p>Staffing policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. A folder containing evidence of current practising certificates</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>for the RNs, GPs, physiotherapists, pharmacist and podiatrists is maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period, except in the case of one new caregiver who was overdue a 90 day appraisal by two months. Non-compliance with orientation, assessment of staff competencies and performance appraisals was identified during the Ministry of Health inspection in August 2018. The improvement required related to performance appraisals is ongoing.</p> <p>Evidence that new staff receive adequate orientation and that existing staff complete annual competencies was verified by staff interviews and a range of documents reviewed. All staff who require them are up to date with their medicine competencies and all other staff had completed competency assessments for infection control, restraint, manual handling and other mandatory topics in early May 2019. The administrator is now maintaining records of these and flagging when these are due to the unit coordinators and CSM.</p> <p>Interview and documentation sighted confirmed that the care home and village manager is identifying and managing performance issues with individual staff.</p> <p>Continuing in service education is planned on an annual basis, including mandatory training requirements, and provided each week. Records showed that these sessions are well attended by all levels of staff who evaluate the usefulness of the education. A majority of staff records reviewed confirmed that 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. The service has a goal to increase the qualifications of care staff with the appointment of a new CSM who is an approved assessor for an industry recognised provider of aged care educational programmes. Twelve of the 13 Registered Nurses are interRAI trained and maintain their annual interRAI competency in undertaking interRAI assessments.</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>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents in the two hospital units. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage in the hospital.</p> <p>The improvement identified during the Ministry of Health inspection (August 2018) with regard to staffing had been resolved, as confirmed by the DHB verification on progress report in December 2018. One of the unit coordinators is currently acting as CSM, and the unit coordinator role was covered by another RN. A suitably qualified replacement</p>

		<p>CSM has been recruited and is due to commence the role in early June 2019. This matter is continuing to be monitored by the care home and village manager and the DHB to confirm sustainability.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic medicine management 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 (refer to 1.2.7).</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Pharmacist input is available on request. Stickers are used to alert staff where there is a second pack of medicines for the resident. Reports are readily available on pro re nata (PRN) medicines administered, and this is noted by the GP when amendments are made to prescribed medicines.</p> <p>A small supply of appropriate medicines are available on imprest for use when required for hospital level care residents.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries. Quantity stock counts are completed at the bottom of every page.</p> <p>The records of temperatures for the medicine fridge were within the recommended range. The acting CSM advised no vaccines are stored on site. When required vaccines are brought by appropriate staff employed at the contracted GP service and administered.</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 monthly GP reviews were consistently recorded on the medicine chart. Allergies, sensitivities or contraindications are consistently noted, and photographs present for each for each resident to assist with resident identification. Medicines have been given as charted or noted refused, withheld or given at another time for a specified reason. Medicine errors or omissions are reported via the incident reporting system, investigated and followed up in a timely manner.</p> <p>One resident was self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner. The resident interviewed confirmed being supported to self-administer inhalers and eyedrops.</p>

		Residents and family interviewed confirmed they were consulted with or advised about changes in medicines.
<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 cooks. The staff members interviewed have completed food safety training and certificates are displayed outside the kitchens. The organisation has a food safety plan, which was audited by Auckland City Council in January 2019 and three areas were identified for improvement. The care home and village manager advises these have been addressed and the service is awaiting the verification of these. The four-weekly winter menu is in use. This has been reviewed by a dietitian to ensure it is appropriate for the service setting. Recipes are present for each menu item.</p> <p>All aspects of food preparation, ordering and storage of food complies with legislation. Temperature monitoring of the fridges and freezers is undertaken daily and recorded. Monitoring is occurring of the temperature of chilled and frozen food on delivery and cooked meals prior to service.</p> <p>The ordering of food is the responsibility of the food supervisor who has been working in the kitchen for five years. There is enough food available on site in the event of an emergency.</p> <p>Positive feedback was received from residents about the food services provided. Residents were seen to be enjoying their lunch which was the main meal for the day. Family members and staff were providing assistance to residents as required. Residents were able to enjoy their meal time and were not rushed.</p> <p>When residents are admitted, the registered nurses discuss the resident's food preferences and/or any special diets which are accommodated as required. Written records detailing individual resident's food allergies, preferences, and dietary needs were present in the kitchen. Kitchen staff interviewed confirmed this information is communicated in a timely manner and updated when there are changes. Special equipment to meet resident's nutritional needs is available. Nutritional supplements and thickeners are available. Nutritional supplements are prescribed and signed for when administered via the medicines management systems. Dietitian input is sought where required and documented in individual resident's files. One resident whose file was sampled is receiving enteral nutrition.</p> <p>The rest home resident audited using tracer methodology had been provided a meal on two occasions in the first two months of admission that contained an ingredient that the resident has a documented allergy to. This was reported via the incident management system and investigated. There have been no further reported events. The resident's dietary needs and allergy information is present in the kitchen.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support</p>	PA Moderate	Information is documented using validated assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and other tools as deemed necessary, as a means to identify any deficits or triggers to inform care planning. Residents and families interviewed confirmed their involvement in the assessment process and the communications with family are documented. Twelve nurses have current interRAI competency. All applicable residents have had an interRAI assessment completed. The hospital resident audited using tracer methodology falls

<p>requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>history was not accurately assessed in their most recent interRAI assessment. Blood glucose level monitoring and fluid and fluid charts are not consistently recorded where required. These are areas requiring improvement.</p> <p>Other assessments are conducted including pain assessments. The results are noted on the electronic medicine record and followed up in a timely manner. Contenance assessments are undertaken utilising a resource provided by the product supplier. The recommended type of continence pad is detailed in the resident's assessment. The two issues identified as requiring improvement in the August 2018 Ministry of Health inspection have been addressed.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>An interim care plan is developed on the day of admission to guide staff and the provision of care. Long term care plans are developed within 21 days of admission and are required to be updated within seven days of the ongoing interRAI assessments being conducted. The long term care plan for the hospital resident audited using tracer methodology did not reflect the resident's current needs. Short term care plans are in use but not consistently. The area identified as requiring improvement in the August 2018 Ministry of Health inspection continues to require improvement. Residents and families reported participation in the development and ongoing evaluation of care plans. As care plans are electronic this participation is documented in family communication records. This shortfall identified in August 2018 during the Ministry of Health inspection has been addressed.</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>	<p>FA</p>	<p>Documentation, observations and interviews verified the care provided to residents was changed in response to changes in the resident's needs, goals or plan of care. Care givers confirmed that they are required to inform the RN or enrolled nurse on duty if they notice any change in the resident's condition, mental status or functioning, and examples were observed during audit. The GP interviewed, verified that medical input is sought in a timely manner, and that medical orders are followed. A range of equipment and resources was available, suited to the levels 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</p>	<p>FA</p>	<p>The activities programme is provided in the rest home by a trained diversional therapist who has completed the national Certificate in Diversional Therapy. There is an activity coordinator on each floor of the hospital wing. One of the two hospital based activities coordinators has started training to obtain the national certificate in diversional therapy. The residents are supported in the rest home 9.30 am/10.00 am to 3.00 / 3.30 pm Monday to Friday, and in the hospital from 9.00 am to 4.00 pm Monday to Friday on the ground floor and 10.30 am to 3.00/3.30 pm on the upper floor. Activities are scheduled on the weekend in each area and facilitated by caregivers on duty. The shortfall from the August 2018 Ministry of Health inspection has been addressed.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful and specific to the residents of all ages. The activities coordinators in the hospital are now having (as at the beginning of May 2019) a different activity programme each day per floor. Both activities programmes are displayed, and residents can choose to participate in activities of their choice on either floor. Participation is recorded for every activity and is voluntary and is evaluated as the next month's activity programme is undertaken and reviewed during the formal care plan reviews.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered including outings, exercise, religious services and entertainment . Residents can provide feedback on the programme through residents' meetings and day to day discussions. One rest home resident noted being unable to go on all the outings they wanted to attend. The facility van has space for two wheelchairs and five residents each outing and a second vehicle that can take five residents is used where required. Lists are displayed of all outings and residents can put their name down for outings they would like to attend. The activities staff review the lists and liaise with residents to ensure participation is shared around the hospital and rest home residents in the event an activity is oversubscribed. The 'what's up at Palms' resident and family newsletter notes in May 2019 that there are seven outings scheduled in the month for Hospital residents and six outings for rest home residents with two outings a combined rest home / hospital activity. The opening hours for the onsite hair salon are also detailed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the electronic progress notes. If any change is noted, it is reported to the RN and appropriate examples were sighted in sampled residents' files.</p> <p>Formal care plan evaluations occur at least every six months in conjunction with the interRAI reassessment and are used to inform changes in the content of the long term care plan and includes progress towards achieving goals. The exceptions are noted in standards 1.3.3 and 1.3.4.2 Where progress is different from expected, the service responds by initiating changes to the plan of care (the exceptions are noted in 1.3.3 and 1.3.5.2). Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, a pressure injury and wounds. Photographs are obtained of new wounds and updated weekly in addition to written evaluation / comments. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress which included via telephone conversations or meeting with staff or the general practitioner. The shortfall identified in the August 2018 Ministry of Health inspection has been addressed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	<p>FA</p>	<p>There is a current building warrant of fitness which expires in September 2019. No alterations have occurred with the buildings since the previous audit.</p> <p>The previous area for improvement raised by the Ministry of Health in August 2018 related to the hot to touch surfaces of the wall heaters in the rest home has been rectified. The heaters have been removed from the walls and</p>

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>a heat pump was installed on 19 September 2018. There were no further issues identified related to the environment during this site inspection.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for a long-term care facility. This includes urinary tract infections, ear, nose and throats infections, skin/soft tissue infections, respiratory and gastro-intestinal infections. When an infection is identified, a record of this is documented on the electronic infection reporting form linked to the resident's electronic file. Surveillance data is collated monthly, for the rest home and hospital and analysed to identify any trends, possible aetiology and required actions via the monthly analysis of clinical indicators report. The surveillance data is benchmarked with other HLL facilities. The RN responsible for providing oversight of the infection prevention and control (IP&C) programme is the unit coordinator (UC) in the rest home. She was unable to be interviewed during audit, however the CSM detailed the required processes and provide copies of surveillance data and evaluation. The infection prevention and control / health and safety committee meet monthly.</p> <p>The results of the surveillance programme are shared with staff and managers, and infection type and rates are displayed each month on the staff notice board.</p> <p>The electronic infection reports were present in applicable individual resident's sampled files. An essential notification was made in September 2018 about a viral outbreak. The UC / IPC coordinator has attended relevant ongoing education including outbreak management.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The nominated restraint coordinator who is an RN/unit coordinator, is capably carrying out the tasks allocated in the role description. The restraint register clearly showed three residents voluntarily using bedrails as enablers and two residents who could not consent, using bedrails for safety. The dates and details for assessment, consent or approval, monitoring and review for these five residents were consistent with the organisation's policy and these standards. The restraint coordinator expressed a clear intent to minimize and eventually eliminate all restraints. There has been a slight change to policy to allow a restraint intervention to be initiated prior to GP approval. The most senior nurse, in consultation with another on duty (or on call) can initiate either bedrails, lap belt or T belt provided a full assessment including risk has been completed, and then ensures a GP approves and signs it off soon thereafter.</p> <p>A restraint committee who used to convene three monthly are now meeting monthly to review all matters related to restraint including staff education.</p> <p>All staff are expected to attend ongoing education on restraint minimisation every six months and be assessed as competent annually. At the time of this audit staff competency with restraint was 100%.</p>

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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies</p>	<p>PA Moderate</p>	<p>Since November 2018, all complaints received are entered in the electronic information management system. Observations on how the information is retrieved from the system, revealed problems with ready access. The manager discovered a complaint that had been entered but not notified to her and a matter that had been acknowledged and was overdue for follow up.</p> <p>Some family and resident interviews revealed a lack of knowledge about how to raise concerns and/or trust in the process. The new manager who has been in the post for ten weeks, has implemented potential solutions by placement of complaint and compliment forms in public places and increasing face to face communication with staff, residents and their families. The moderate risk rating reflects the ongoing issues with complaints management.</p>	<p>The care home and village manager is not always notified by staff when complaints are entered into the electronic system.</p> <p>The electronic system does not flag when progress on complaints has stalled, nor provide the right amount of detail on the front</p>	<p>Ensure that the right to complain and the processes for raising concerns and complaints are known and trusted by residents and relatives.</p>

with Right 10 of the Code.			<p>screen about the issue and/or people concerned to allow ready identification.</p> <p>Three of the residents and three family members interviewed expressed reluctance to raise complaints as they were wary of potential consequences and/or did not think their concerns would be taken seriously. One family member had to ask around about who to approach with concerns.</p>	<p>Develop systems for alerting when new data is entered, when progress on an open complaint is due and to allow ready access and identification of the logged complaints.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and</p>	<p>PA Moderate</p>	<p>The inspection by the Ministry of Health in August 2018, identified that performance appraisals were overdue. This non-compliance was checked by the DHB the following December and a plan was in place to remedy the matter. The new care home and village manager who took up the role in March has since discovered the plan has not been fully implemented. A new corrective action plan is in place that includes oversight and monitoring by administration and management staff. Step one of the process has been implemented with an anticipated completion date by end of June 2019.</p> <p>The moderate risk rating reflects the ongoing nature of this non-compliance.</p>	<p>Five of the seven staff files reviewed were overdue for performance appraisals, which included a 90 day review for a new staff member.</p>	<p>Ensure staff performance appraisals occur annually and after three months for new staff.</p> <p>60 days</p>

effective services to consumers.				
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>Verbal handovers are provided between shifts. The oncoming RN / EN and senior caregiver receive a handover from the proceeding shift RN / EN. The senior caregiver is responsible for communicating changes in residents' care needs with the other caregivers on the oncoming shift. This is not consistently occurring. While there are examples of appropriate communication occurring, caregivers advised they do not always know who the senior caregiver is on the shift, and do not always get a handover about residents they are responsible for. As an example, caregivers identified they did not know a resident had fallen earlier until the resident vocalised discomfort during personal cares and it was then noted the resident had fallen earlier in the day. The senior caregiver on duty had not communicated to other caregivers on their shift that a resident had been vomiting earlier in the day. The care home and village manager introduced a change on the second day of audit requiring the registered health professional to be responsible for shift handover communications to all staff. These changes are yet to be imbedded in practice and evaluated for effectiveness.</p> <p>Registered nurses do a written handover per shift of residents in their care who have changing care, incidents and exceptions. The RN / EN on each shift write a report for the residents they are responsible for. This report is reviewed by the CSM and the care home and village manager and examples were sighted.</p>	<p>Information about residents' current needs and health status is not being reliably communicated to caregivers via shift handovers.</p>	<p>Implement more effective systems for coordinating and sharing important information about residents' current needs to the people who are providing the care to them</p> <p>30 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and</p>	<p>PA Moderate</p>	<p>InterRAI assessments are conducted within 21 days of admission and reviewed at least every six months thereafter. Processes are in place to identify when these assessments are due and specific nurses are allocated the responsibility for ensuring the assessments are conducted within the required timeframe.</p> <p>The hospital resident audited using tracer methodology has recently had their interRAI assessment updated. The assessment incorrectly noted the resident has not had any falls in the last 90 days, when the resident is noted to have had three falls in this period of time (refer to 1.3.3).</p> <p>Food and fluid monitoring charts are in use. These were consistently completed in the sampled applicable files in the rest home but not consistently completed in the hospital area. On occasions in the hospital units, caregivers had recorded details about fluid or</p>	<p>The interRAI assessment of a hospital resident who has had three falls including a fall that resulted in an admission to the DHB hospital, was noted to have not had any falls in the last 90 days.</p> <p>Monitoring of blood</p>	<p>Ensure accurate assessments are undertaken and documented consistently.</p> <p>60 days</p>

<p>are documented to serve as the basis for service delivery planning.</p>		<p>fluid administered as a narrative in the progress notes instead of on the applicable form, and on other occasions enteral feeding was recorded in the medicine administration records, however the volume was not consistently included along with the water flushes on the fluid balance chart.</p> <p>One resident is having adjustments made to diabetes medicines. Blood glucose levels (BGL) were requested to be checked four times a day. In the nine days sampled (not including the day of audit), BGL were recorded four times for one day only, checked three times on four days, twice on three days, and once only on one day.</p> <p>Assessments made by the general practitioner and contracted / employed allied staff are documented at the time of each consultation.</p>	<p>glucose and food / fluid charts is not consistently occurring as requested, or information is being recorded in multiple places (hospital).</p>	
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>An interim care plan is developed on the day of admission to guide staff in the provision of care. The template used is appropriate to the service setting.</p> <p>Most long term care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information including the interRAI assessment. The hospital resident audited using tracer methodology did not have their long term care plan updated to reflect the resident's significantly changed needs for mobility, continence management and communication (refer to 1.3.3). While some interventions occurred, a short term care plan was not developed, or the long term care plan updated when the resident had two falls in a week period, or for changes in challenging behaviour although some changes in interventions / care and monitoring were occurring. Another resident had two falls in under two weeks. A short term care plan was not developed to detail falls prevention strategies nor was the long term care plan updated. Another resident was noted to be attempting to hit staff or touch staff inappropriately. While interventions are occurring, a clear plan to address these behaviours was not sighted. These aspects were discussed and verified with the unit coordinator or registered health professional on duty.</p> <p>Medical staff and employed / contracted allied staff document a plan of care at the time of consultation. Medical and allied health professionals' notations are clearly written, informative and relevant and any instructions are communicated to nursing staff. Applicable issues / changes in care required are not always clearly communicated to caregivers (refer to 1.3.3.4). Residents and families reported participation in the development and ongoing evaluation of care plans.</p>	<p>Care plans are not always sufficiently detailed to provide interventions for individual residents, for example, communication, catheter management and transfers.</p> <p>Short term care plans are not consistently developed for example, falls and challenging behaviours.</p>	<p>Ensure care plans contain details for each resident in every situation.</p> <p>60 days</p>

		Monitoring is occurring of resident's weight at least monthly and plans implemented where there are significant variances either increased or decreased. Food and fluid balance charts are not consistently documented where required (refer to 1.3.4.2).		
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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.

No data to display

End of the report.