

The Coast to Coast Hauora Trust - Heritage 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](#).

The specifics of this audit included:

Legal entity: The Coast to Coast Hauora Trust

Premises audited: Heritage Rest home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 2 July 2019 End date: 3 July 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: 10

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 |
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| | 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 |
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| | 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

Heritage Rest Home provides rest home level care for up to 17 residents. The service is operated by the Coast to Coast Hauora Trust. A manager and a registered nurse / clinical manager are responsible for the services provided and report to the board of trustees. There have been no significant changes to services or the management team since the last audit. Ongoing facility renovation is occurring. Residents and family members interviewed spoke very positively about the care provided.

The 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 and family members, management, staff and two general practitioners.

This audit has resulted in a continuous improvement in relation to the activities programme and identified three areas requiring improvement relating to complaints management, one aspect of medicine records management, and ensuring all infections are included in the surveillance programme.

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. | | Some standards applicable to this service partially attained and of low risk. |
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. Resident's choices are respected including via the development of advance care plans.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is available.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to 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 and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

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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. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family. The multidisciplinary team, including the clinical manager/registered nurse and a general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are stored securely and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. The rest home has a registered food safety plan and holds an 'A grade' food safety rating. Residents and family members verified satisfaction with meals.

Safe and appropriate environment

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

Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers or restraints were in use at the time of audit. Policy contains a comprehensive assessment, approval and monitoring processes and identifies that a regular review will occur. Policy states that the use of enablers is voluntary for the safety of residents. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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. | | Some standards applicable to this service partially attained and of low risk. |
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The infection prevention and control programme is led by the registered nurse/clinical manager and aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is available when needed.

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

The infection surveillance programme is relevant to the service setting.

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) |
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| Standards | 1 | 41 | 0 | 2 | 1 | 0 | 0 |
| Criteria | 1 | 89 | 0 | 2 | 1 | 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 |
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| Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation. | FA | Heritage Rest Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The clinical manager, general practitioners and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. This includes for outings / transport, release of health information, photographs and to share a room (when applicable). Advance care planning, establishing and documenting enduring power |

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| | | <p>of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Copies of enduring power of attorney (EPOA) and welfare guardian documents are kept on file, along with documentation (where applicable) verifying that the EPOA document has been activated.</p> <p>Residents' records sampled contained advance care plans using the To Tatou Reo framework. Residents were also encouraged to detail their wishes in regard to escalation of clinical care (cardiopulmonary resuscitation, use of antibiotics, transfer to the district health board hospital, and use of specific fluid and nutrition). Residents' choices and associated documentation have been reviewed at least annually for competent residents.</p> <p>Staff were observed to gain consent for day to day care activities. Participation in activities is voluntary.</p> |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>During the admission process, a discussion occurs with the resident and family about the Code and Advocacy Service. Posters and brochures related to the Code and Advocacy Service were also displayed in the rest home. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical manager is actively working with Aged Concern to facilitate independent support / advocacy for a resident that does not have other ready advocacy / supports.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities and entertainment. Staff ensure residents are ready in time for any planned outings or visits.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and can come at any time. Family members are encouraged to accompany the resident to external health</p> |

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| | | <p>appointments.</p> <p>Family members confirmed they were comfortable in their dealings with staff.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | PA Low | <p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that there had been no complaints received over the past year. Policy identifies what actions are to be taken, through to an agreed resolution, documentation requirements and timeframes. However, two documented complaints sighted had not been documented in the complaints register to meet policy requirements. The clinical nurse manager is responsible for complaints management and follow up. Care staff interviewed confirmed a sound understanding of the complaint process and who they report to.</p> <p>There have been no complaints received from external sources since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through discussions on admission and via posters displayed in the rest home. The Code is displayed in the entrance area and in English, Māori and sign language in one of the lounges. Information on advocacy services and complaint / feedback forms are present at the entrance area.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and</p> | FA | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All</p> |

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| independence. | | <p>residents currently have a single occupancy room. Staff advise residents only share a room with their prior written consent.</p> <p>Residents are encouraged to maintain their independence by attending community activities, participating in rest home activities including some cooking activities and helping set the tables, and undertaking the activities of daily living they are safely able to complete. Care plans included documentation related to the resident's individual abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Residents and family members interviewed verified the residents individualised needs are comprehensively met.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and as part of the ongoing education programme. Residents and family members interviewed were very complimentary about staff and had no concerns about how staff treated, interacted or communicated with the residents, other staff, and family members.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | FA | <p>One resident identifies as Māori and confirmed that staff acknowledge and respected their individual and cultural needs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a Māori health plan. Support and specific guidance on tikanga best practice is available from staff employed by the local iwi health provider (Te Ha Oranga) in Wellsford. A staff member from this organisation was present during the opening meeting and reports that there is a long standing mutually supportive relationship between Te Ha Oranga and the Coast to Coast Hauora Trust. A representative from Te Ha Oranga is normally on the Coast to Coast Hauora Trust although this position has recently become vacant.</p> |

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| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | FA | <p>Residents and family members verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed and the care plans are signed by the resident and or designated next of kin. Examples sighted included spiritual needs, or that the resident did not wish to participate in religious activities, or that the resident did not believe in vaccinations.</p> <p>The resident satisfaction survey confirmed that individual needs are being met.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Staff were commended by residents and family members interviewed for creating a safe and homely environment.</p> <p>The induction process for staff includes education related to professional boundaries, and expected behaviours. The organisation's expectations related to staff conduct are also clearly detailed in staff employment contracts present in all staff files sampled.</p> <p>Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. There have been no concerns raised by staff, residents or family since the last audit.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <p>The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, gerontology nurse specialist, wound care specialist, mental health services for older persons, and medical specialists including via the DHB outpatient service. The two general practitioner's (GP's) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to specialist feedback received.</p> <p>Staff reported they receive good support for internal and external</p> |

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| | | <p>education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included encouraging all competent residents to document advance care plans.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. This was supported by documentation for applicable events in the residents' records reviewed.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required. All current residents can speak English. One recent short stay resident had English as a second language. The resident was admitted on the days where one of the staff on duty could also converse in the resident's first language.</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 monthly reports to the manager/trustee (manager) and annual reports to the board of trustees showed adequate information to monitor performance is reported including occupancy, quality data, emerging risks and issues.</p> <p>The service umbrella management oversight and fiscal responsibility is undertaken by the board of trustees. One trustee is the operational manager (manager) of the service. The day to day responsibility for care services is undertaken by the clinical nurse manager who is a registered nurse and holds relevant qualifications. The clinical nurse manager has been in the role for eight years. Responsibilities and accountabilities are defined in a job description and individual</p> |

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| | | <p>employment agreement. Both the manager and the clinical nurse manager confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through appropriate ongoing education at both clinical and management level.</p> <p>The service holds an Age-Related Residential Care (ARRC) contract with Waitemata District Health Board (WDHB) for rest home level care services including respite. Nine residents were receiving services under the ARRC contract at the time of audit. All residents are rest home level of care. One resident was funded by Accident Compensation Corporation.</p> <p>On some occasions the service receives residents under an individual Primary Options for Acute Care (POAC) contract. There were no residents under this contract at the time of audit.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | FA | <p>When the manager is absent, the second in charge, with oversight from the trustees, carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the manager with assistance from the charge nurses from Coast to Coast Healthcare medical centre which is owned and operated by two of the trustees. Both of whom are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</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> | FA | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, wound care and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings and reported to the board of trustees at least quarterly or sooner if required. Quality indicators include occupancy, hospital admissions, falls, skin tears, medication errors,</p> |

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| | | <p>staffing, wandering/aggression, laundry, complaint/compliments and infection control. Staff reported their involvement in quality and risk management activities through audit activities and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (June 2019) which had a 100% resident return rate, showed that one resident would like more outings. All other respondents were very satisfied with all services. The issue of more outings was followed up and has been resolved to the resident's satisfaction.</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 are based on best practice and were current. There is a documented review process for all policies and procedures. 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 manager and clinical nurse 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>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the manager monthly and quarterly to the board of trustees. All incident and accidents are discussed at staff meetings.</p> <p>The clinical nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health or District Health Board since the previous audit. There have</p> |

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| | | been no police investigations, coroner's inquests, issues based audits and any other notifications made. |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>Human resources management 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 practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are 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 with annual performance reviews which are up to date.</p> <p>Continuing education is planned on a bi-annual basis, including mandatory training requirements. Care staff confirmed regular ongoing education related to their role is presented both on-site and off-site by the registered nurse and guest speakers. 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. An off-site assessor manages the training programme. The clinical nurse manager (registered nurse) is trained and maintains their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals for interRAI.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. 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</p> |

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| | | <p>interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of four-week rosters 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.</p> <p>The clinical nurse manager works three days a week and is on call. There is a cook from 7am to 2pm seven days a week. An activities coordinator works five hours one day a week. The care staff undertake the cleaning and laundry along with planned activities as part of their everyday role. The manager is available on call and visits the facility regularly throughout the week. Two of the board of trustee members are the local general practitioners who provide medical care to residents.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>All necessary demographic, personal, clinical and health information was completed in the residents' files sampled for review. Clinical notes were current and integrated with allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database, and general practitioner records on MedTech. The MedTech records are accessible at both the rest home and at the general practice rooms. The progress notes reference the GP review and any subsequent changes in the plan of care. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p> | FA | <p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service as rest home level care. Prospective residents and/or their families are encouraged to visit the facility prior</p> |

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| services has been identified. | | <p>to admission and are provided with information about the service and the admission process. The organisation seeks updated information from the NASC and for any residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | FA | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services, and ensure relevant information is communicated. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient transferred to the local acute care facility showed timely escalation of care. Family members interviewed report being kept well informed of any changes in the resident's condition and escalation of care with consideration of any advance directives the resident has put in place prior.</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> | PA Moderate | <p>The medication management policy is current and includes required components to meet these standards. The standing orders comply with legislation.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. All medicines are checked against the medicine</p> |

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| | | <p>record on delivery and again at the time of administration. All medications sighted were within current use by dates. Pharmacist input is provided on request or as part of the review prior to the interRAI assessment being updated.</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. There are no vaccinations or other medications that require a cold chain process to be implemented. All vaccinations are provided by the GP practice. No medications currently require refrigeration.</p> <p>There are two residents who self-administer either an inhaler or nitro-glycerine spray. The clinical manager is responsible for ensuring patients are safe to do so, and document this in the resident's file. Both residents are required to advise staff when they use these medicines and examples of this were sighted in the applicable resident files. A resident interviewed who was self-administering one medicine could clearly articulate what the medicine was, when it would be taken and why and that staff were to be promptly informed.</p> <p>There is an implemented process for the reporting, management of, and analysis of medication errors.</p> <p>One aspect of medicine documentation does not align with current accepted practice and this is an area requiring improvement.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>The food service is provided on site by the kitchen team. There are two staff responsible for cooking. One works Monday to Thursday and the other Friday to Sunday inclusive. The menu has been reviewed and audited in 2017 by a dietitian which is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns on a four-week rotational menu, and the main meal is provided at mid-day, and home baking for between meal snacks and supper is provided. The winter menu is currently in use.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation</p> |

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| | | <p>and guidelines. The service has an approved food safety plan, which has been audited by the local City Council with an expiry date of 29 July 2019. An 'A' grade food rating has been issued. A repeat audit has been booked for later this month. Refrigerator storage temperatures are monitored daily and within the required range. All staff have undertaken food handling training.</p> <p>Residents can assist with some cooking activities or loading the dishwasher and setting the meal table if they want. During audit the residents had made fresh dough with the intent to make fresh bread rolls to go with their evening meal.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile is developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. The resident's expressed satisfaction with the food services, confirmed their preferences are facilitated and the serving size is more than required. One resident has put on five kilograms since admission. Prior to admission they had had significant weight loss.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | <p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident 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, the clinical manager advised a referral for reassessment to the NASC would be made and a new placement found, in consultation with the resident and whānau/family. In exceptional circumstances, the rest home would consider applying to the funder for a temporary variance in the level of care that can be provided for a specific resident.</p> |

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| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>Information is documented using validated nursing assessment tools such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. Carers undertake a 'top to toe' assessment weekly when the resident has a shower and document any changes in skin integrity that may not have been previously noted. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the clinical manager / registered nurse. The clinical manager has current competency for conducting interRAI assessments. Residents and families confirmed their involvement in the assessment process.</p> <p>Prior to the interRAI assessments being reviewed / updated, members of the multidisciplinary team including the pharmacist, GP, activities staff, carers and resident / family are consulted about changes and the resident's progress to achieving their current goals.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. Short term care plans were appropriately developed in sampled files for new issues including wounds, infections, changes in elimination need or behaviour. Carers interviewed confirmed they are advised of changes in residents' care plans in a timely manner.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to</p> | FA | <p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of</p> |

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| meet their assessed needs and desired outcomes. | | care. All resident interviewed were very satisfied with the quality of care and service delivery at Heritage Rest Home. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The two GPs interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and that the residents are receiving appropriate care. Carers confirmed that care was provided as outlined in the documentation. A range of equipment and resources / consumables was available, suited to the level of care provided and in accordance with the residents' needs. |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | CI | The activities programme is provided by an activities coordinator who is allocated five hours a week as the activities facilitator. In addition, caregivers are specifically rostered for assisting with activities every day, including individual and group-based activities. A resident wellness project has been undertaken over a 12-month period aimed to improve resident's quality of life, mood and participation in meaningful and enjoyable activities. This is an area of continuous improvement. |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Resident care is evaluated by carers on the 24-hour record of care and reported in the progress notes when applicable and appropriate. If any change is noted, it is reported to the clinical manager / RN who is normally on call when not on site. The clinical manager / RN makes entries in the progress notes at least weekly or sooner where applicable.</p> <p>Formal evaluation of care plans occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and use of short term care plans. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for wounds management, infections, changes in elimination and falls minimisation. When necessary, and for unresolved problems, long term care plans are added to and updated. Wound care charts are</p> |

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| | | used to record the condition of the wound and details interventions provided. Photographs are also used. The results of laboratory investigations, and analysis are present in resident files sampled. At least monthly weight and vital signs are recorded for each resident, or sooner where requested / indicated. The results are monitored over time and variances reported to the GP. |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>Residents are supported to access or seek referral to other health and/or disability service providers, or their refusal of referral offer is noted. Designated general practitioners from the Coast to Coast GP practice provide onsite GP services, and visit weekly on Tuesday or sooner if required. Residents may choose to use another medical practitioner.</p> <p>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 wound care nurse specialist, gerontology services, skin specialists, and gynaecologist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if required.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Safe chemical handling education is incorporated into staff orientation and then presented two yearly as part of the ongoing education programme. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p> |

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| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>A current building warrant of fitness (expiry date 30 June 2020) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment (May 2019) and calibration of bio medical equipment (December 2018) was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The board of trustees manage and approve all maintenance which is carried out by contractors.</p> <p>Residents confirmed that they were very happy with the environment.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | <p>FA</p> | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility which have been renovated to a high standard since the previous audit. There are seven bedrooms which have toilet ensembles. Separate visitor and staff toilet facilities are available. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | <p>FA</p> | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are three bedrooms which are large enough to be shared rooms but on the days of audit all bedrooms were single occupancy. Double bedrooms are only shared once approval has been sought from the resident. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p> |

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| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>Communal areas are available for residents to engage in activities. There is one dining room with a spacious lounge area at one end. A second smaller lounge houses the library area which is maintained by a community volunteer. Both lounge areas are used for activities. All areas enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | FA | <p>Laundry is undertaken on site in a dedicated laundry as part of the care staff daily duties. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>Cleaning is undertaken as part of the care staff members daily duties. The chemicals are labelled and stored in a secure area one end of the laundry. Staff have completed safe chemical handling education.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | FA | <p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 22 August 1997. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 04 June 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including blankets and a gas BBQ were sighted and meet the requirements for up to 17 residents. The Ministry of Civil Defence and Emergency Management recommendations for the region are met by</p> |

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| | | <p>the service which has appropriate stocks of water and food. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time by staff on duty. Residents and staff confirmed they feel safe.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by heat pumps in common areas and individual electric heaters in residents' bedrooms. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The clinical manager/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined and documented.</p> <p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by an infection control manual. The infection control programme is dated 2019 to 2023. An annual review of the infection control clinical indicators was sighted for 2018, and a copy of this is provided to the manager and board of trustees.</p> <p>Infection control matters, including surveillance results, are reported monthly to the manager. Infection prevention and control is discussed at the quarterly staff meetings.</p> <p>Signage is available to request 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 the infective period for commonly transmitted illnesses. Staff interviewed advised they do not come to work when sick. Annual influenza vaccination is offered free to</p> |

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| | | <p>consenting residents and staff.</p> <p>There have been no outbreaks since the last audit.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | <p>The clinical manager is the IPC coordinator and has appropriate skills, knowledge and qualifications for the role. The clinical manager has been in this role for seven years and has attended relevant study days / education, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP's and practice nurses, and public health unit, as and if required. The local practice nurses provide all staff and resident vaccinations.</p> <p>The clinical manager has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard. Some policies have been developed by Heritage Rest Home. An older version of an infection control manual developed by an external IC consultancy service is also available on site.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate hand hygiene, use of personal protective equipment and food safety. Hand washing facilities and sanitisers are available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified external health professionals as well as the IPC coordinator, and</p> |

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| | | <p>includes the industry approved qualification carers are encouraged to complete. A record of attendance / completion is maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, management of wounds, and ensuring adequate hydration.</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> | PA Low | <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, wound, skin and soft tissue, eye, ear, gastro-intestinal, the respiratory tract, influenza, multi-drug resistant organisms (MDRO's) and outbreaks. If a resident is suspected of having an infection the clinical manager is informed. The resident is reviewed by the GP as applicable and treatment commenced where indicated. New infections and any required management plan are discussed at shift handover, to ensure early intervention occurs. This was observed during audit. The surveillance data sighted did not include all applicable infections noted in sampled residents' files.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator (registered nurse) 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.</p> <p>On the day of audit, the facility was restraint free with no residents using restraints or enablers. The restraint register showed that restraint has only been used once, from 11 to 20 March 2019, where bed side rails were used for safety reasons only.</p> <p>Policy identifies that enablers are the least restrictive and used voluntarily. A similar process is followed for the use of enablers as is used for restraints. Policy has appropriate assessment, monitoring and review forms to meet the requirements of the standard.</p> |

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| | | Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and from interview with staff. |
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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) |
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| <p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | PA Low | <p>The service has a complaints register which showed the last recorded complaint was in 2017. Two minor documented complaints contained within one resident's file had no documented follow up nor was this information shown in the complaints register. Policy requires all complaints to be documented and followed up. The clinical nurse manager stated that she had followed up on the complaints but that they had not been documented.</p> | <p>Two minor documented complaints sighted were not shown in the complaints register.</p> | <p>Ensure the complaints register is maintained and includes all complaints and the actions taken to resolve the complaint.</p> <p>180 days</p> |
| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing,</p> | PA Moderate | <p>There is a master register of the prescriber's signatures. Carers record their sample signatures on each resident's medicine administration record. The date is recorded for the</p> | <p>When the medicine chart needs to be rewritten, the medicines on the medicine chart (including the medicine name, dose, frequency and</p> | <p>Provide evidence that the documentation related to required / prescribed medicines is consistently documented on residents'</p> |

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| administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | | commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines are met. Allergies are noted. A photograph is present in the medicine charts for resident identification. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines. Medicines are given as prescribed or noted refused or withheld. The clinical manager / RN routinely documents the names of all medicines in use, as well as the dose, frequency and route on the new medicine chart, when the prior version of a medicine chart needs rewriting for any reason, and then provides this to the GP for review and signing. | route) is being transcribed by the registered nurse onto a new medicine chart then given to the general practitioners for signing. | medicine charts by an authorised prescriber as required by best practice guidelines. 30 days |
| <p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p> | PA Low | Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Infection rates are compared with the same month the previous year as well as the previous calendar month. Infection rates are also reported to the manager and the board. While infections are being reported and included in the surveillance data, this is not consistent. Three of the four infections detailed in the sampled residents' files have not been included | Three out of four residents' infections documented in sampled residents' files have not been reported in the 2019 infection surveillance programme. | <p>Include all residents' infections in the infection surveillance programme.</p> <p>180 days</p> |

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| | | in the 2019 surveillance data to date. | | |
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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 audit.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | <p>The activities programme is provided by an activities coordinator or caregivers that are specifically rostered for assisting with the activities. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. There is a facility cat, and one resident has a small dog. The resident's activity needs are also evaluated as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual and group activities and regular events are offered. In addition, a wellness project was undertaken over 12 months to improve</p> | <p>A project was undertaken over a 12 month period in 2018 and 2019 aimed to increase resident participation in the Heritage life and promote greater enjoyment of life and wellbeing. This included identifying root causes for lowered mood and reasons why residents declined activities and outings. The programme included reviewing all activities provided and broadening the options available occurring both in the rest home and activities that are community based. Activities are planned for each resident with consideration of their physical capability, mental capability and interests. Formal evaluations were conducted with each resident and carers on a three monthly basis, with further changes made to activities offered. A 'plan - do - check - act' quality improvement cycle was used. The effectiveness of changes made were formally evaluated via staff, family and</p> |

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| | | resident participation in activities and enhance wellbeing. Residents interviewed confirmed they find the activities programme appropriate and varied. | resident satisfaction surveys. Residents are now more frequently contributing to the Heritage family by helping with 'home-making' activities. Overall there has been improved resident moods and connections with each other. |
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End of the report.