Heritage Lifecare Limited - Colwyn House

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:	Colwyn House
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 17 September 2019 End date: 18 September 2019

Proposed changes to current services (if any): On 22 January 2019, the residents in Pohutukawa unit and Matai unit were collectively moved. This resulted in an increase in dementia care beds that are now located in Matai from 20 to 24 beds and a reduction in psychogeriatric beds (now located in Pohutukawa unit) by four beds (previously 24 beds and now 20 beds). Both Matai unit and Pohutukawa unit are secure units and suitable for the provision of either dementia level care or psychogeriatric level care.

Total beds occupied across all premises included in the audit on the first day of the audit: 63

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Heritage Lifecare Limited – Colwyn House provides care for up to 67 residents requiring psychogeriatric, medical and geriatric hospital level care as well as secure dementia level 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 family members, a general practitioner, managers and staff. A new interim care home manager has been employed since the last audit (started 1 July 2019). A new clinical services manager was appointed to the role in early July 2019. She previously held the unit coordinator role. A new unit coordinator commenced on 15 July 2019.

In January 2019, the residents in Pohutukawa unit were transferred to the Matai unit and those in the Matai unit to the Pohutukawa unit, thereby increasing the number of available dementia level care beds by four and reducing the psychogeriatric beds by four. Both Matai unit and Pohutukawa unit are secure units and suitable for either dementia level care or psychogeriatric level care. Both have secure external/garden areas. A change to the fire evacuation plan was not required in relation to this change.

The service has moved to an electronic clinical record system since the previous audit.

There were no areas requiring improvements from the previous certification audit in January 2018. At this audit there are six areas identified as requiring improvement related to complaints management, analysing clinical indicator data, corrective action planning, the hazard register, essential notifications, and staffing.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.

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 are available.

The complaints management policy aligns with requirements. Complaints and concerns are acknowledged in writing, investigated and the results of investigation are reported and shared as appropriate. The Office of the Health and Disability Commissioner have been involved in two complaints since the previous certification audit. Both complaints remain open.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. An experienced and suitably qualified person manages the care home, supported by the clinical services manager and the unit coordinator.

The quality and risk management system includes collection of quality improvement data, internal audits, conducting annual resident, relative and staff satisfaction surveys, restraint minimisation, and monitoring resident infections. Adverse events are being reported. Actual and potential risks are identified, and mitigation strategies put in place. Policies and procedures support service delivery and are available in the staff team room.

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. Staff are rostered to work in designated units. There are always at least two registered nurses on duty.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including the registered nurses and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

Medicines are safely managed and administered by staff who are competent to do so.

Nutritional meals, snacks and fluids are provided in line with recognised nutritional guidelines. Special dietary requirements are catered for. Family/whanau verified satisfaction with meals provided to the residents.

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.

There was 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.

The organisation has implemented policies and procedures that support the minimisation of restraint. No residents were using enablers. Ten residents were using restraints at the time of audit. The use of restraints and enablers is monitored monthly.

Infection prevention and control

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	1	3	0	0
Criteria	0	32	0	2	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Concern / complaint forms and compliment forms are available by the visitors sign in book. The complaint process is described in the residential agreement and in the information pack given to family members on admission. The interim care home manager is responsible for complaints management, with the support from the Heritage Lifecare Ltd (HLL) national support office who facilitate responses to any external complaints. Senior staff interviewed demonstrated a good understanding of the complaint process and what actions are required from them. One complaint has not been included in the Colwyn House complaints register and is an area requiring improvement. Family members interviewed stated on occasions there is insufficient staff (refer to 1.2.8.1) and there is insufficient furniture in the lounge and dining rooms for when family members visit. Corrective action plans are not consistently developed in response to sampled complaints (refer to 1.2.3.8). The service is also documenting and communicating all compliments received to staff.
Standard 1.1.9: Communication Service providers	FA	The service provider understands the principles of open disclosure, which are described in policy. Family members stated they were kept informed about any changes to 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

communicate effectively with consumers and provide an environment conducive to effective communication.		information reviewed in residents' records, complaint and incident reports. 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. There is one resident who does not communicate verbally. There are staff employed who can communicate with the resident in their first language.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	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 HLL operations and quality managers included information to monitor performance including occupancy, complaints, incidents, staff vacancies, human resources issues, and any other emerging risks and issues. The interim care home manager (ICHM) who has been in the role since 1 July 2019, holds a relevant qualification (is a registered Social Care Manger) and has over 30 years' experience working in, or managing age care facilities including overseas. The ICHM is a 'Certified Practitioner in Dementia Care' (from the International Council of Dementia Practitioners). The ICHMs responsibilities and accountabilities are defined in a job description and individual employment agreement. The ICHM 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 / dementia care. The ICHM is supported by the clinical services manager (CSM), who is currently on leave, and the unit coordinator (UC). Both are experienced registered nurses in aged related care residential care services. The CSM was employed at Colwyn House initially as the unit coordinator in April 2019 before being appointed to the CSM role on 5 July 2019. The unit coordinator was employed on 15 July 2019. The unit coordinator is covering key components of the CSM role in her absence. Advertising has just commenced for a permanent care home manager. The service holds contracts with Hawke's Bay District Health Board (HBDHB) for age residential care (ARC) residential aged care – continuing and dementia level care, aged residential hospital specialised services - continuing care services specialised level one and two, long term support chronic health conditions (LTCHC) and respite/day care services. There were five residents receiving services weekdays under the day programme contract. This was not included in the scope of this audit. The facility has a maximum capacity of 67 certified beds, now comprised of 24 dementia level care beds in Matai unit and 45 beds in the two psychogeriatric units. Pohutukawa unit contains 20 beds and Kowhai unit contains 25 beds. On the days of audit 63 beds were occupied, which included 18 residents in the secure dementia unit, at rest home level of care. There were 41 residents in the psychogeriatric units receiving high dependency (hospital) level of care. In addition, there were four residents under the age of 65 years receiving services under the LTCHC contract, one at dementia level care and three at psychogeriatric level of care. There were no residents staying for

		respite/short stay care on the days of audit. Three family members interviewed advised the service met with them in December 2018 about the proposed relocation of the residents to another unit and consent was subsequently sought and provided. The relocation of residents all occurred on the same day (22 January 2019) and external movers were contracted to assist with this process.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate	The organisation has a planned quality and risk system, and documented quality and risk plan for the period March 2018 to March 2020. The quality and risk programme includes monthly audit activities and monitoring of outcomes, resident, relative and staff satisfaction surveys. The reporting of incidents / accidents, restraint minimisation and monitoring residents' infections also occurs. This, along with other clinical and non-clinical indicators is benchmarked with other Heritage Lifecare Ltd (HLL) care homes. Records demonstrating review and analysis of Colwyn House data was not able to be located for the period April to July 2019 (refer to 1.2.3.6) and is an area requiring improvement. The resident and relative satisfaction surveys have been recently undertaken. These surveys are facilitated nationally by HLL in May 2019. The results have been analysed and were expected to be released in the week following this audit. A staff satisfaction survey was conducted in July 2019. This is also facilitated and analysed nationally by HLL. The results will be released once analysis has been completed. Internal audits are undertaken to monitor key aspects of service delivery including, but not limited to, care planning, medications, hand hygiene, managing behaviours that challenge, monitoring restraint, the environment and the hot water temperatures. The majority of audits sampled have been carried out as scheduled or soon after excluding July 2019. Corrective action plans have not been consistently developed in response to audit findings and complaints. (Refer to 1.1.13.3 and 1.2.3.8). This is an area requiring improvement. Regular formal facility wide meetings have not occurred with family members with the exception of meeting related to relocating residents (refer to 1.2.1). The ICHM is currently developing a database of all next of kin email details in order to commence a regular email newsletter for family members. Three monthly 'care and share' meetings are being planned for family members at Colwyn House. In the interim, the ICHM is meeting with small groups of residents to get feedback from them directly. Two meetings have been held to date, one in August 2019 in Kowhai unit and one in September 2019 in Pohutukawa unit. In response to resident feedback, a 'happy hour' has commenced Friday afternoons where residents are provided with non-alcoholic soft drinks and snacks. This is reported to be very popular with the residents. A small sunny corner has been allocated as a quiet reading area in Pohutukawa unit, and a bookcase and magazines provided. The facility manager described the processes for the identification, monitoring, review and reporting of organisation risks and development of mitigation strategies. A Colwyn House hazard register was unable to be located (refer to 1.2.3.9). This requires improvement. A 'communications cover sheet' is issued monthly by HLL. This summarises key business, operation and quality and

		risk communications from HLL nationally and notes any actions required, including by Colwyn House management team. Linkages to enable the ICHM to access and review more detailed information if required is included for each topic noted in this communication summary. The ICHM reported this is an excellent communication system. A monthly meeting of the registered nurses occurs. The health and safety committee, and the staff meeting also occurs monthly. There are documented terms of reference for these meetings. Two or three meeting minutes were sighted for each of these meetings. The RN meeting minutes for September have yet to be written up. This is expected to occur when the CSM returns from leave. 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 current accepted practice and were located for staff to access in the staffroom. The documents are developed nationally by HLL, referencing relevant sources, and are approved then distributed to Colwyn House. New or significant changes to policy is discussed at staff meetings. Copies of new of significantly changed policies were placed in a file for staff to read and sign. The administrator is responsible for the document control processes including ensuring the removal of obsolete documents.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	Since the move to an electronic resident clinical records management system in January 2019 staff are required to input all resident related adverse and near miss events into the electronic database. Other events are being reported on paper-based forms. A sample of incidents reviewed including medication errors, falls (with and without injuries), a skin tear and bruises, confirmed that the incidents are reported by staff in a timely manner, are investigated by the registered nurses, and relevant individual interventions have been provided and detailed in the patients' records. This includes the development of short-term care plans where indicated. Reported events are given a severity assessment code (SAC). The ratings used are those used by the Health Quality and Safety Commission with information on SAC rating processes available for applicable staff on the share drive. Events are subsequently reviewed by the unit coordinator and/or the CSM. They also check who has been notified of the incident. Open disclosure had occurred for applicable events sampled. Adverse event data is collated and reported as clinical and non-clinical indicators. Detailed analysis of themes and trends was not available for review for April to July 2019 (refer to 1.2.3.6). The ICHM could detail the type of events that require essential notification. Some records are available to demonstrate this process, however the records located at Colwyn House are incomplete. In addition, records are not available to demonstrate that one applicable event (the death of a resident that was reported to the Coroner) has been notified as required. The ICHM was aware that registered nurse shortages are now required to be reported as a Section 31 notification, as communicated from the clinical and quality team at HLL.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	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 for the RNs, general practitioners (GPs), pharmacist and podiatrists is maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and responsibilities. Nine staff records reviewed showed documentation of completed orientation, or the staff are new, and their orientation is still in progress. A performance review has occurred within a three-month period and annually thereafter for applicable staff. Existing staff are required to complete annual competencies relevant to their roles. This was verified by staff interview. All staff are required to complete these competencies during the month of September and records are maintained of completion. There was a large number of completed competency documentation on the CSM desk pending her review on return from unplanned leave. All applicable staff have a current medicine competency. Other competencies include infection control, restraint, manual handling, and other competencies specific to roles. The CSM is maintaining records of these and when these are next due. Continuing in service education is planned on an annual basis, including mandatory training requirements, and in-service education is provided most weeks and includes a topic to meet contractual requirements and these standards. Records are retained to verify attendance. All except three care staff employed more than eighteen months have completed a New Zealand Qualification Authority education programme in dementia care (refer to 1.2.8.1). There are at least 13 staff (including two registered nurses) currently doing this training. Three of the 12 registered nurses have a current interRAI competency in undertaking interRAI assessments, and one RN is currently in training. Twenty staff have a current first aid certificate. There is always at least one staff member (normally more) on duty with a current first aid certificate.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate	There is a documented process for determining staffing levels and skill mixes in order to provide safe service delivery, 24 hours a day, seven days a week (24/7). An afterhours on call roster is in place that is shared week about by the UC and the CSM. The unit coordinator is currently covering key aspects of the CSM role. The ICHM is available 24/7 for non-clinical issues. Staff confirm that access to advice is available when needed. Family members interviewed noted that on occasions there are insufficient staff on duty, and there is a high resident falls rate. Three applicable staff have not completed industry approved training in dementia levels as required in the contract with HBDHB.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The staff observed administering medicines 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. Current medication administration competencies were sighted for all staff who administer medication. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription when medication is received from the pharmacy. All medications sighted were within current use by dates. The service has implemented an electronic medication management system. Staff have completed relevant training for the new system and other topics required for medicine management as per the training records. The three medication trollies are stored in a locked room when not in use. A safe process for staff administering medicines was observed during audit. Interviewed staff demonstrated knowledge on controlled drugs management and storage requirements and are guided by the medication management policies and procedures when required. The pharmacist completes an audit six monthly and this was last performed in June 2019. The required three-monthly medication review is consistently recorded on the medicine chart by the GP. On the reviewed medication charts, dates were recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were met. Monthly reviews/audits are completed from the electronic system utilised and reports were sighted. There were no residents able to self-administer medicines due to the nature of the service provided at Colwyn House. There is an implemented process for comprehensive analysis of any medication errors. The approved reconfiguration has had no impact on the medication management.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service	FA	The food service is provided on site by two experienced cooks and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows a four weekly cycle pattern. The service has a contracted dietician who has audited the menu plans within the last two years. The main meal is provided in the evening at this facility. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the food safety plan. The two cooks interviewed have undertaken a safe food handling qualification. Kitchen hands have also completed all relevant training and certificates are displayed. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Food allergies are documented and included in the care plan.

delivery.		Evidence of resident satisfaction with meals was verified by family interviews. Residents were seen to be provided with adequate time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There was not enough furniture present to enable family members to sit with residents they were assisting with meals (refer to 1.1.13.3). The service has a current food control plan which expires 19 December 2019. This is displayed at the entrance to the facility. The reconfiguration has not had any impact on the food service.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse and complex range of residents' individualised needs was evident. The GP medical records verified that medical input is sought in a timely manner and that medical orders are followed, and care is implemented as required. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. Interviewed family members confirmed satisfaction with the care provided but felt there was not adequate staff cover at times when they visited (refer to 1.2.8.1).
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by two diversional therapists and three permanent and one casual activities co-ordinators that cover the three wings of the facility. All were experienced and passionate about their roles when interviewed. One activities coordinator is enrolled to complete level 4 diversional therapist training currently. The activities staff are fully supported by the interim care home manager (ICHM) who has developed the newly implemented cognitive stimulation and therapeutic programme which is displayed in all service areas. The activities are planned to cover the 24 hour period on a daily basis. The 24 hour clock dementia level care assessment records were reviewed, and times were documented when individual residents were awake or restless and/or needing additional activities and behavioural management. Staff interviewed understood the requirements for working with residents in both the dementia service and the psycho-geriatric wings at this facility. Resources are available and accessible in all services to meet the needs of the residents at these times. A social assessment and history is undertaken on admission to ascertain the residents' needs, previous interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to individual residents. The resident's activity needs are evaluated six monthly and as part of the formal six-monthly reviews. Activities reflected resident's goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Families/whanau are involved in evaluating and improving the

		programme. One staff member assists with van outings and the 'men's group' every Tuesday. The team leaders organise which residents are well and able to go on outings in the community. Family of some individual dementia care residents take their family member out for drives in the community or to visit family. Activities for residents under 65 years of age (four in total – three receiving psychogeriatric care and one in the dementia care service) and secure dementia unit residents are specific to the needs and abilities of the people living at this home. Individual recreational plans were reviewed for the under 65 year old residents and one on one activities were also provided and documented by the staff. The approved reconfiguration has had no impact on the planned activities programmed implemented.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes by the care staff. If any change is noted, it is reported to the RNs. The RNs review and document in the progress notes when there is need or changes in residents' conditions and weekly as a minimum. The duty coordinator RN discussed the Colwyn House schedules for the RN primary nurses to complete the interRAI assessments, lifestyle care plans and arrange the GP review dates in a timely manner. The interRAI assessments were up to date. The RNs not competent in interRAI have responsibilities to update the care plans from the outcomes/triggers from the interRAI re-assessments and this system is working effectively. Care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessments, or sooner as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated for acute infections and wounds in the reviewed files. Unresolved problems were added to the long- term care plans after three weeks. Families/whānau interviewed confirmed involvement in evaluation of progress and any resulting changes. There is provision in the electronic system for recording when family/whanau are informed for any incidents or changes in health status or for any other reasons. Short term care plans were closed off when the short-term problems had been resolved.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	There is a current building warrant of fitness issued 27 February 2019. The facility gas safety systems have been reviewed and a certificate of compliance was sighted dated 28 August 2019. The residents in Pohutukawa unit and Matai unit have swapped units. Dementia care beds are now located in Matai unit and psychogeriatric beds are now located in Pohutukawa unit. Both Matai unit and Pohutukawa unit are secure units and suitable for either dementia level care or psychogeriatric level care. Both have secure external / garden areas and sufficient bathroom and communal spaces. A change to the fire evacuation plan was not required in relation to this change.

for their purpose.		
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The nurse responsible for infection prevention and control activities reviews all reported infections. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. The clinical indicator monthly summary was reviewed. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against the previous month and year and this is reported to all staff and the infection control committee. Data is benchmarked externally with the other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The nominated restraint coordinator is the unit coordinator and is carrying out the tasks allocated in the role description. The restraint register noted ten (10) psycho-geriatric residents are using a form of restraint (eight chair support briefs and two bedrails are in use). The dates and details for assessment, consent or approval, monitoring and review for the residents were consistent with the organisation's policy and these standards. The restraint coordinator expressed a clear intent to minimise and eventually eliminate all restraints, however restraints in use were for safety purposes. No enablers were in use. The use of enablers and restraints is reviewed monthly as a component of the RN/EN and team leader meetings.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	Review of the complaints system and register confirmed 14 complaints have been received since 3 December 2018. This included complaints from a family member of a past resident who had made several complaints while their family member was receiving services. This family member was contacted during audit as requested by a HealthCERT adviser. The family member was not satisfied with how complaints made had been managed by the previous management team. A review of eight complaints verified that the complaints have been acknowledged in writing, investigated and follow up communications sent to the complainant within required timeframes. While response letters to complaints detailed actions to be taken, a clear process to ensure the required actions have been implemented and monitored for effectiveness was unable to be verified for at least three of the complaints	The complaints register does not include details of the complaint received via the Health and Disability Commissions Office on 27 August 2019. Family members stated there is insufficient furniture in the lounge and dining rooms for visitors to use.	Ensure the complaints register includes all complaints received, and actions undertaken. Ensure sufficient furniture is available for residents and their visitors.

		sampled. Clear action plans were present for the more recently received complaints along with evidence of follow-up (refer to 1.2.3.8). The family of a resident who is no longer receiving services made a complaint to the Office of the Health and Disability Commissioner in April 2019. Another complaint to the HDC was received in 27 August 2019. Both complaints are open. The August 2019 complaint has not been recorded in the Colwyn House complaints register. It was documented on a separate electronic spreadsheet that was accessible to the regional clinical and quality support manager. All family members interviewed of current residents were aware of the complaints process. All the family members of current residents spoke highly of the staff, however, noted that staffing levels are at times insufficient (refer to 1.2.8.1). The family members also stated that there was not enough furniture in the communal dining room's and lounge areas to enable them to sit with their family member including while assisting their family member during mealtimes. This was also observed during the audit. Some family members noted they had commented to the previous management team about the lack of furniture available but had not made a formal complaint. However, asked that that this issue be noted and addressed.		90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	The organisation, Heritage Lifecare Ltd (HLL), uses the same system for each of its facilities to report a range of data which is then collated and used for benchmarking. Each care home receives a monthly quality indicator report that shows the number of reported complaints, compliments, falls, pressure injuries, skin tears, bruises, residents with weight loss, challenging behaviours, medication errors, restraint, infections and skin tears. The CSM is to review this data and provide a monthly narrative report to the care home manager and the national quality team. The CSM report summarising Colwyn House clinical indicator data, possible reasons for trends, and the planned or actual actions taken to remedy unwanted trends were sighted for March	There are a range of clinical indicators linked to the events/incident reporting process. Records are not available to demonstrate that detailed analysis of these events, including themes and trends, has	Ensure clinical indicator data is reviewed and analysed in a timely manner, with appropriate interventions undertaken based on

		and August 2019 only. Records of any analysis and interventions for the period April to July 2019 were not available for review during the audit. The ICHM and the regional clinical and quality support staff member were not employed during the earlier part of this period, and completed reports were not locatable in either the electronic or paper records checked. The falls data for 2019 identifies there have been between 35 and 62 reported falls per month; the majority are falls result in no injuries. One resident's fall resulting in a fracture was reported in July 2019. The lowest fall rate is reported for July 2019 and the highest rate was reported in February 2019. The majority of falls are occurring in the psychogeriatric units, with more falls in the afternoon each month excepting August 2019, and more falls occurring of residents in Kowhai unit. A comprehensive review of falls data was reported to have recently occurred, however the ICHM, the unit coordinator and the regional clinical and quality support manager were unaware of this. They had not seen the report and were unaware of any recommendations/findings made (refer to 1.2.4 and 1.2.8.1). The two clinical indicator reports sighted included some analysis of falls and noted how many residents have had more than one fall and the totals.	occurred for the period April 2019 to July 2019 inclusive. Actions taken in response to clinical indicator data was not available for review except for March and August 2019.	findings. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	Corrective actions were undertaken in response to the individual resident incidents/accidents sampled. Internal audits are regularly occurring (refer to 1.2.3). However, analysis of data and/or the development of corrective actions plans for some of the sampled audits were not documented. For example, the management of behaviours that challenge audit, the hand hygiene audit in May 2019, and the clinical file audit in April/May 2019. Action plans were developed following the most recent completed audits. A review of eight complaints verified that the complaints response letters to complaints detailed actions to be taken. However, a clear process to ensure the required actions have been undertaken and monitored for effectiveness was unable to	Corrective action plans are not consistently developed when areas for improvement are identified including in response to complaints and internal audit findings.	Ensure corrective action plans are consistently developed when areas for improvements are identified and are implemented and monitored for effectiveness

		be easily verified for at least three of the complaints sampled. One family member was interviewed for a complaint which has not yet been closed and the family member expressed concerns about how complaints had been managed. Clear action plans were present for the more recently received complaints along with evidence of follow-up (refer to 1.1.13.3). Actions required are also noted as a component of meeting minutes. This is included in the meeting minute templates.		in a timely manner. 90 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Low	The ICHM is reporting on new and changing risk via the managers' monthly reports. The July and August 2019 reports were sighted. Interventions have occurred in response to risk with some amendments made recently to staffing hours (refer to 1.2.8.1) and a change in pharmacy providers. The ICHM has established a set time for the general practitioner to undertake routine weekly visits. This now occurs every Tuesday morning at 9am. The ICHM is meeting weekly with staff from the HBDHB mental health old persons service (MHOPS) to discuss a variety of issues including identification and request for MHOPS input into the care needs for identified residents, and to discuss current occupancy, wait list and prioritisation of prospective residents, restraint use, and staffing. The hazard register template is present in the quality manual. This was required to be individualised for Colwyn House. Staff and managers were not able to locate a Colwyn House specific hazard register during audit, although four new hazards have been recently reported and mitigation strategies detailed on the reporting forms, and new hazards are discussed at the H&S meetings.	A hazard register for Colwyn House could not be located.	Ensure Colwyn house hazards are identified, and mitigation strategies implemented and monitored over time. 90 days
Criterion 1.2.4.2 The service provider	PA Moderate	The interim care home manager understood the requirements for essential notification reporting, including for pressure injuries. Section 31 forms are completed by the ICHM (or previous	The essential notification records held at Colwyn	Ensure complete records are

understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.		manager) then sent to the HLL national support office for review. The notifications to the Ministry of Health (MoH) are made centrally by designated personnel at HLL national support office following their review. The essential notification records at Colwyn House are paper based and located in a designated folder. Some associated documentation is present in an electronic register and associated file accessible by the regional clinical and quality support manager. The available records at Colwyn House showed ten notifications of events have been made to the Ministry of Health, since January 2018. These include the change in care home manager, a security event (intruder), alleged staff misconduct, fire alarm associated events, and a pressure injury. However, for some reported events, the Section 31 notification detailing the events were not present, and only the MoH acknowledgement letter was on file (for example, MoH letters dated 22 January 2018, 15 February 2019, and 11 June 2019). The electronic file included information related to an essential notification made on 9 January 2019 about a resident absconding. There is no information on this event in the Colwyn House records. The electronic register noted the death of a resident in June 2019 was reported to the Coroner. Records were not available to demonstrate this had been reported as an essential notification.	House is incomplete. Section 31 documents detailing the circumstances of reported events are not present for some reported events. Records were not available to demonstrate that the death of a resident in June 2019, reported to the Coroner has been reported as an essential notification.	available in Colwyn House to demonstrate that all applicable events are being reported as essential notifications. 60 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	The permanent care home manger position has been advertised. The ICHM advised there is one full time equivalent caregiver role vacant and casual RNs, caregivers and activities staff are also being recruited. Since the ICHM appointment, changes to staffing has occurred. There is now an RN rostered on duty in Matai unit each weekday in the mornings. One of the afternoon caregivers is starting an hour earlier in the afternoons (starting at 4pm instead of 5pm) in both Kowhai and Pohutukawa units. Discussions are occurring with another staff member about the future redeployment to a different support role. The roster is developed by the CSM with support from the ICHM and UC. The roster is published at least two weeks in advance.	Three care staff who have been employed more than eighteen months have not completed an industry approved dementia care qualification. All family members interviewed spoke highly of staff but noted that on	All care staff complete industry approved dementia qualifications within eighteen months of employment. Review staffing to ensure

		Work is underway to develop a fixed and rotating roster. An RN is rostered on duty mornings seven days a week to undertake interRAI assessments. This RN also assists clinically if required. The unit coordinator and the CSM work weekday mornings. The ICHM works 7.30am to 4pm weekdays. Staff are rostered to work in designated units. There is always a minimum of five caregivers rostered on duty and two registered nurses. When there are only two registered nurses on duty they are based in Kowhai and Pohutukawa units. In the afternoon and nights, the RN in Pohutukawa provides oversight of care in Matai unit. The caregiver hours vary in each unit. However, there is least two caregivers working full shifts morning and afternoons and between one and two additional staff working part shifts in each unit on morning and afternoon shifts. If staff want to swap a shift, they are required to complete a 'swap shift form' and submit for prior approval. Where staff did not attend a rostered shift due to unplanned leave, the shift was covered by employed staff or external agency staff in the last two historic rosters sighted with infrequent exception. The RN on duty is responsible for arranging staff cover. The ICHM maintains records of the roster variances and if necessary, Colwyn House utilises agency staff who are familiar with the facility and residents. All family members interviewed of current residents and the family member of a past resident advised there is insufficient staff on duty at times. This occurs when residents require the assistance of two staff for all their cares and at times due to the layout of the unit staff may be assisting a resident in their room and staff are not therefore, visible in the communal areas. Activities staff interviewed commented that they are required to assist residents at mealtimes which has previously been the role of the care staff. A cleaner is rostered to work in each unit daily from 8am to 3pm. There are four regular cleaners in the team and one casual cleaner. There are two cooks that share the roster working 8am to	occasions there are insufficient staff available for the provision of resident care. There is a high resident falls rate.	staffing and skill mix facilitates safe service delivery and a reduction in falls. 90 days

		4.30pm seven days a week. There is a tea assistant every day from 10.30am to 7pm. There are two diversional therapist (DT) employed with three other permanent activities staff and one casual employed. Activities are scheduled in each unit from 9.30am to 4pm seven days a week. The maintenance person assists with driving the vehicle for outings and the 'men's club'. Additional hours are rostered for gardening, administration, and maintenance, laundry and household assistants. The falls data for 2019 identifies there have been between 35 and 62 reported falls per month, the majority are falls resulted in no injuries. The lowest fall rate is reported for July 2019 and the highest rate was reported in February 2019. The majority of falls are occurring in the psychogeriatric units. More falls are reported in the afternoon each month excepting August 2019, with the highest number of falls normally occurring in Kowhai unit. Review of staffing in relation to this data was not sighted (refer to 1.2.3.6). Three applicable staff employed more than 18 months have not completed industry approved qualification in dementia care as required by the provider's contract with HBDHB (refer to 1.2.7).		

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.