# Heritage Lifecare (GHG) Limited - Somerfield House

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

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

**Premises audited:** Somerfield House

**Services audited:** Dementia care

**Dates of audit:** Start date: 30 September 2019 End date: 1 October 2019

**Proposed changes to current services (if any):** This provisional audit was undertaken in preparation for the sale of the Golden Healthcare Group’s facility of Somerfield House to Heritage Lifecare Limited, which will bring its name to Heritage Lifecare (GHG) Limited - Somerfield House.

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

# Executive summary of the audit

## Introduction

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

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

## General overview of the audit

Somerfield House provides rest home dementia services for up to 41 residents. The service is operated by Golden Healthcare Group and managed by a facility manager with support from a corporate services manager, a clinical manger, a quality manager and a relief manager/training coordinator. Heritage Lifecare (GHG) Limited is currently purchasing this facility, which instigated the need for this provisional audit.

This provisional 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, interviews with family members, managers, staff and a general practitioner. Interviews with residents were undertaken but most were with family members who spoke positively about the services provided at Somerfield House. An interview with the prospective provider was undertaken.

One area in relation to the annual review of the infection control programme was identified as requiring improvement.

## Consumer rights

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

Somerfield House provides services that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were observed to be responsive to residents’ requests and noted to be interacting with residents in a respectful manner.

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

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

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

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

Family members and residents are informed about the complaints process at the time of admission. A complaints register is maintained and confirmed that the few complaints filed are resolved promptly and effectively.

## Organisational management

A business plan and a quality and risk management plan include the scope, direction, goals, values and mission statement of the organisation as well as key performance objectives. Monitoring of the services is provided to the governing body of the current provider. Experienced and suitably qualified people manage the organisation and the facility respectively.

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 families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Hazards are managed according to a register. Policies and procedures support safe service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good human resources practices. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual staff performance review.

The rosters demonstrated that staffing levels and the skill mix meet the needs of residents requiring dementia care.

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

## Continuum of service delivery

The staff of Somerfield House work closely with the local needs assessment and service coordination service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident and the resident’s family to facilitate the admission.

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

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

The planned activity programme is overseen by a diversional therapist and an activities co-ordinator. The programme provides residents with a variety of individual and group activities seven days a week and maintains their links with the community. A facility car is available for outings.

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

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

## Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical and bio-medical equipment have been tested as required. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing when applicable. Chemicals, soiled linen and equipment are safely stored. Some laundry is undertaken onsite and some offsite with cleaning and laundry processes being evaluated for effectiveness.

Staff are trained in emergency procedures and fire evacuation procedures are regularly practised. Emergency systems are in place and additional supplies and equipment are available for use in the event of any emergency. A call bell system is in place. Security systems applicable for a dementia service that ensures the safety of residents are maintained.

Communal and individual spaces are maintained at a comfortable temperature. All residents’ areas have natural light filtering through them.

## Restraint minimisation and safe practice

The organisation has policies and procedures that support the minimisation of restraint and meet the requirements of the standard. There were no enablers or restraints in use at the time of audit. Staff demonstrated a sound knowledge and understanding of restraint and enabler processes and noted that they would be unlikely to use an enabler as the use of one is voluntary and the residents all have a degree of dementia.

## Infection prevention and control

The infection prevention and control programme, led by an experienced and appropriately trained infection control co-ordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board.

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

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

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 44 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Somerfield House (Somerfield) has processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, outings, invasive procedures and collection of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s file. Staff demonstrated their understanding by being able to explain situations when this may occur.  Except for one file, all files reviewed had Enduring Power of Attorneys (EPOA) in place and activated. The one file where this had not occurred had evidence to verify a Protection of Personal Property Rights (PPPR) was in the process of being applied for.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents family members or EPOAs are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff were aware of how to access the Advocacy Service. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints and feedback 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 about the process. A box for anonymous written feedback sits near the front entrance of the rest home.  The complaints register was reviewed and showed that three complaints were reported in 2018 and five have been received in 2019 to date. Records on file included related correspondence, the corrective action taken to an agreed resolution and the complainants level of satisfaction with the outcome. All had been responded to within required timeframes and quality meeting minutes showed improvements have been made where relevant. The facility manager is responsible for complaints management, although consults with the clinical manager if the complaint is of a clinical nature. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Family members of residents reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas around the facility, together with information on advocacy services, how to make a complaint and feedback forms.  The prospective provider is aware of their obligations in regard to adhering to the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Family members of residents confirmed that residents receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and during discussion with families and the general practitioner (GP). All but two rooms in Somerfield are single rooms. The two shared rooms are available for married couples if required. At the time of audit, one double room was occupied by a single resident. The other had two residents in. Privacy was optimised with curtains between spaces and quiet spaces accessible for privacy in conversation. Consents to share a room had been signed, including the family’s acknowledgement of the ability to revoke that consent at any stage. Evidence is sighted of compatibility between the residents sharing a room.  Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is one resident in Somerfield at the time of audit who identifies as Māori. Documentation, observations and interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is an individualised Māori health plan developed for the resident with input from the resident and the resident’s family. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Family members of residents verified that they were consulted on the residents individual cultural values and beliefs and that staff respect these. Resident’s personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A residents family satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met, and this supported that individual needs are being met. A resident of European descent has been enabled to have contact with a cultural support group that has provided staff with resources and cue cards to enable effective communication strategies should the resident choose to not speak in English. An interview with the cook identified several interventions in place to address the differing food preferences related to the cultural diversity of the residents at Somerfield. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Family members of residents stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A GP also expressed satisfaction with the standard of services provided to residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Somerfield encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, mental health services for older people, the psychiatrist, access to online training and study days, diabetes nurse specialist and a physiotherapist. All care staff have or are in the process of being trained to care for residents with dementia. Residents family members reported staff are caring, willing to help and to ‘go the extra mile’ in making the residents days full of fun and laughter in a pleasant homely environment. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they feel well supported by management and receive management support for external education and access their own professional networks, such as on-line forums, to support contemporary good practice.  Other examples of good practice observed during the audit, included an environment that evidenced a prompt response in managing residents’ potential deterioration in medical status and implementing de-escalation strategies to prevent behaviours that challenge from impacting on others. The unit was settled and peaceful. The residents were relaxed and quietly pottering around doing chores of their choosing. Families were complimentary of the care being provided by Somerfield. A range of resources, trinkets and memorabilia was accessible to residents throughout the unit, enabling conversation triggered by memories. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Family members of residents stated they were kept well informed about any changes to their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services can be accessed via local interest groups when required. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services were often required when the resident’s dementia progressed, and English was not the resident’s 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 | Somerfield House is one of seven aged care facilities, plus one mental health facility, in Christchurch that are owned by the Golden Healthcare Group. The Golden Healthcare Group is a family owned and operated business with more than 30 years in the industry. There are five members of the executive team who contribute to the running of the company. A 2019 – 2024 strategic plan for the wider organisation outlines the purpose, values, scope, direction and goals of the organisation. Documents sighted described annual and longer-term objectives and included associated operational plans for both the organisation and for Somerfield House. The corporate services manager described the type of information that is discussed with the company director most weeks, informed that occupancy and financial reports are provided to the executive team, (now also to the Chief Executive Officer of Heritage Lifecare Limited), and noted that an operations manager oversees everyday issues. Somerfield House has its own facility manager who meets with the corporate services manager on a weekly basis and supplies quality meeting minutes and information about key incidents and potential risks as applicable. A sample of various reports showed adequate information to monitor performance is reported through to the governance team.  The facility manager for Somerfield House service has had experience working in a variety of levels within the care industry for more than 30 years. This person has had previous management and leadership training, been in former management roles and has specific expertise in health and safety and dementia care. Although this person commenced in the role only a few weeks prior to the audit, she is being well supported by the team at Golden Healthcare Group and other facility managers. Responsibilities and accountabilities are described in a role description that was sighted.  The facility holds a contract with the Canterbury District Health Board CDHB, for age related residential care (ARRC), dementia services. One of these residents was under 65 years of age. There were 40 of the 41 dementia rest home care beds at the Somerfield House occupied on the day of audit. The vacant bed was in a shared room. No residents were receiving respite services under the ARRC contract.  An interview was undertaken with the new provider of Heritage Lifecare Ltd (HLL) in September 2019. Heritage Lifecare Ltd is an established New Zealand aged care provider, operating more than 2300 beds in the sector. This proposed acquisition of Golden Healthcare Group facilities will add a further seven facilities in the Canterbury region. An organisational structure document for HLL was sighted and details the reporting lines to the board that are currently in place. The acquisition of GHG is planned to be different from the other purchases of facilities around the country over recent months as the seven Golden Healthcare Group facilities will continue to be run as a group with the current corporate services manager of the Golden Healthcare Group reporting directly to the HLL CEO. Although the seven facilities will be known as Heritage Lifecare (GHG) Limited, and the current Golden Healthcare systems will be maintained.  The Heritage Lifecare (GHG) Limited transition plan sighted onsite is led by an experienced and well-qualified project team who are specifically focussing on the legal and financial aspects of the acquisition rather than the integration of the current GHG facilities into the Heritage Lifecare Limited group. The transition plan does not include provision of infrastructure support such as providing information technology capability including hardware and software. Heritage Lifecare Limited reported that GHG staff will be invited to the usual regional HLL workshops as relevant to any future planned introduction of documentation, and new HLL systems and processes. There are no immediate changes planned for staff at Somerfield House. The prospective purchaser had notified the relevant District Health Board and HealthCert prior to the provisional audits being undertaken. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The Golden Healthcare Group operations/human resources manager currently relieves when the corporate services manager is absent, and these processes will continue meantime. During absences of the facility manager, a Golden Healthcare Group relief manager/training coordinator, who relieves all facility managers of GHG facilities and was in the relief manager role before employment of the current facility manager, will take on the role. A senior registered nurse coordinator who works between several GHG facilities is available for any absence of clinical staff. Both the relief manager and relief registered nurse are experienced in the sector and able to take responsibility for any issues that may arise. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Golden Healthcare Group (GHG) has a quality management policy and a current planned quality and risk plan dated January to December 2019, which reflected the principles of continuous quality improvement. These documents include management of incidents and complaints, internal audit activities, regular resident and family satisfaction surveys, monitoring of outcomes, and management of clinical incidents including infections, falls and medication. Key performance indicators for Somerfield House have been identified and are being monitored. Two monthly quality and risk meeting minutes were reviewed. These confirmed regular review and analysis of quality indicators is occurring. Related information is being reported and discussed at the GHG organisation’s management team, quality and risk team, registered nurses’ and staff meetings. Staff reported their involvement in quality and risk management activities through learning and development, internal audit activities, meeting attendance and incident reporting. Those interviewed were familiar with the terminology and latest analyses of quality related data. Relevant corrective actions are developed and implemented to address any shortfalls and a corrective action register is being maintained. Family satisfaction surveys are completed annually with the most recent survey completed earlier in 2019. The results showed overall satisfaction with suggestions around improved communication taken seriously and corrective actions developed.  Policies reviewed were current, comprehensive and cover all necessary aspects of the service and contractual requirements. The document control system ensures a systematic and regular review process, approval, distribution and removal of obsolete documents. Although Heritage Lifecare Limited has its own applicable policies and procedures that meet the requirements of the Health and Disability Services Standards, there are no immediate plans to transfer these over to Somerfield House.  An organisational risk register for 2019 covers potential risks with annual reviews evident. Processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies were discussed and being implemented. All managers interviewed were familiar with the Health and Safety at Work Act (2015), especially the facility manager, and requirements are being implemented.  Heritage Lifecare (GHG) Limited will continue to operate the current GHG quality plan and reporting systems within all seven facilities in the group. The corporate services manager Golden Healthcare Group has started to provide monthly reports that include summaries about quality and risk management issues to the Heritage Lifecare Limited Chief Executive Officer. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse and near miss events on accident/incident reporting forms. A sample of incidents forms reviewed showed these were fully completed. The facility manager informed that any new form is checked each morning and documentation sighted showed incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the quality and risk manager and ultimately to management, quality and risk management meetings, nurse and Somerfield House staff meetings.  The facility manager and the quality and risk manager described essential notification reporting requirements, including for pressure injuries. They advised that an earlier outbreak had been reported to the public health office and that there had been a notification of a significant event to the Ministry of Health; this had involved police and a coroner. Documentation sighted and verbal reports provided confirmed that appropriate responses had been provided when requested. Although the formal coroner’s report has not yet been received, the service provider had been informed of the conclusion and there were no further actions or follow-up required. There are no current legislative compliance issues of concern that are likely to affect the service. |
| 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 | Human resources management policies and processes are based on good employment practices and relevant legislation. The recruitment process includes formal application, an initial interview, 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.  Staff orientation includes all necessary components relevant to their role. Staff reported that the orientation process prepares new staff well for their role but suggested some additional time could be added now there is so much more to cover. Staff records reviewed showed documentation of consistently completed induction and orientation processes.  Continuing education is planned each year including mandatory training requirements over two-year timeframes. Self-learning tools are used to complement training sessions when staff do not get to attend. Good training records demonstrated where staff were up to regarding their education with all care staff having either completed or commenced a New Zealand Qualification Authority education programme. A staff member is the internal assessor for the programme and the relieving manager/training coordinator is available for additional staff support with training. One of the caregivers has recently gained proficiency as a peer manual handling coordinator. All staff in Somerfield House except one have completed the required education to work in a dementia service and the outstanding caregiver has completed all but one paper. There is currently only one full time trained and competent registered nurse after recent resignations, however records sighted confirmed two others are commencing shortly. The senior registered nurse/coordinator is providing additional support meantime. Both registered nurses are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of required training and of annual performance appraisals. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is 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). A rostering policy covers staff levels and skill mixes as well as health and safety related limitations such as on the number of consecutive shifts a staff person may work. As noted in standard 1.2.3, these policies and practices will be maintained following the purchase of the Golden Healthcare Group in the foreseeable future. However, as a current provider of other aged care services, the Heritage Lifecare Limited does have its own policy in relation to staff skill mix managing staff rosters and staff changes.  Rotating rosters are being implemented as per details of the four-week rotation on time target. Rosters indicated information of the caregiver’s level of their national qualification, medication competency and first aid status as well as whether they are dementia trained. A registered nurse is on duty from 8am to 4.30pm Monday to Friday and on call at all other times. The facility adjusts staffing levels to enable additional oversight of a resident who becomes more distressed or agitated. An afterhours on call roster for manager and registered nurse cover is in place, with staff reporting that good access to advice is available whenever needed. Care staff reported there were adequate staff available to complete the work allocated to them. Family interviewed supported this and were full of praise for the calibre of the staff at the Somerfield House. Observations and review of a four-week roster cycle confirmed adequate staff cover had been provided for all unplanned absences, with staff replaced by casual staff or permanent staff wanting an additional shift to cover any unplanned absence. The roster confirmed reports that at least one staff member on duty has a current first aid certificate and at least two have a medication competency. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.  Electronic medication records are stored in a secure portal. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are admitted to Somerfield when they have been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service and specialist services that the care offered by Somerfield is required by the resident. Prospective residents and their family members are encouraged to visit the facility prior to admission and meet with the facility manager (FM) the registered nurse (RN) or the organisation’s clinical manager (CM). They are also provided with written information about the service and the admission process.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and admission agreements signed by the EPOA. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Canterbury District Health Board’s (CDHB) ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Eye drops and ointments have been dated when opened.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted included the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.  Residents of Somerfield are not able to self-administer medications.  Medication errors are reported to the RN and CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.  Standing orders are not used. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in April 2018. Recommendations made at that time have been implemented.  A food control plan is in place and registered with the Ministry of Primary Industries (MPI), due to expire 2 July 2020. A verification audit of the plan has not occurred at this time.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. The dietician provides yearly training to kitchen staff on safe food handling.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is available.  There is access to the kitchen and food items for residents at any time day or night.  Evidence of resident satisfaction with meals was verified by resident’s weight records, observations, family members interviews, satisfaction surveys and resident/family meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.  An initiative to present blended meals in shapes that reflect the meals content, has been implemented after it was noted that three residents requiring these meals were observed to lack interest in the meal. The addition of the shape moulds has improved interest; however, this has only been implemented recently and has not yet been evaluated. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received by Somerfield, but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family members of the resident are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the clinical co-ordinator. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission residents of Somerfield are initially assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, behaviour assessments, social and activity assessments and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents’ changing conditions require.  In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident’s condition changes. Interviews, documentation and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs.   All residents have current interRAI assessments completed by the two trained interRAI assessors on site. InterRAI assessments are used to inform the care plan. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | All care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.  Behaviour management plans were comprehensive identifying triggers to behaviours and strategies to manage those behaviours.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the care provided to residents at Somerfield was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Interventions for behaviours favoured the use of de-escalation strategies and distraction. If a change in medication was required, any change was closely monitored for its effectiveness. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme at Somerfield is provided by a diversional therapist (DT) and an activities co-ordinator seven days a week.  A social assessment and history are undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. All residents’ files contained a twenty-four-hour activities plan that includes all aspects of the resident’s life and past regimes. The resident’s activity needs are evaluated regularly and as part of the formal six-monthly care plan review. The environment is conducive to meeting the needs of the residents and the era of the resident’s life experiences. A range of trinkets, photos, household items and memorabilia fill the unit. Residents were observed dusting with an old feather duster and discussing old photos on the wall. A ‘Menz Shed’ in the courtyard has rakes, an old vice, tools, and an old lawnmower. A gentleman was noted to be sweeping up the leaves. A vegetable garden was seen to be providing the kitchen with a good source of well cared for vegetables, tended to by the residents.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included an exercise programme, daily chores, visiting entertainers, housie, ball games, quiz sessions and daily news updates. Several more able residents accompany the DT out in the care to attend to daily chores. During the summer months a range of activities occur outside in the enclosed courtyard. The activities programme is discussed at the twice-yearly residents and family members meeting. Meeting minutes indicated resident and family member input is sought and responded to. Interviews, observations and family satisfaction surveys demonstrated satisfaction with the activities offered. Any feedback is used to improve the range of activities offered. A newsletter is created every three months and informs families of past and future events. Residents family members confirmed they believe the programme meets the needs of the residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The care of residents at Somerfield is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections, behaviours, medication changes, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as a wound management plan was evaluated each time the dressing was changed. Family members of residents interviewed provided examples of how they are included in the evaluation of care provided at Somerfield and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to older persons’ mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. An organisational hazard register was last reviewed 2018. Updates that are facility specific to various areas of Somerfield are documented and have been reviewed.  There is provision and availability of protective clothing and equipment for use when indicated and staff were observed using these. Hand sanitiser is readily available throughout the facility. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness with an expiry date 1 April 2020 was publicly displayed.  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 and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. An annual maintenance schedule was sighted, evaluations of new equipment were documented, the environment was hazard free and resident safety was promoted. The prospective purchaser has no intention to make any changes to the environment in the short term.  External areas are safely maintained and were appropriate for the residents with dementia. These included special interest external courtyards, which residents could mobilise in and out of as they choose. Appropriate seating with shelter and shade is available.  Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Evidence of this was sighted in maintenance request records. Family members were happy with the environment, which they described as ‘restful’ and ‘homely’. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility with all residents’ rooms having their own ensuite and toilets beside the lounge areas. The walls of the ensuites are tiled for easy cleaning, appropriately secured and approved handrails are in place and hand-held showers in situ. Equipment such as shower chairs and other accessories are available to promote residents’ independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Although personal rooms are of varying sizes, there is sufficient space in each bedroom to enable residents and staff to move around safely. Only one of two double bedrooms was occupied with two residents. Permission has been granted by family members for this to occur until a single room became available; however, the two people are managing so well together that this plan may not eventuate. Rooms are personalised at varying levels with furnishings, photos and other personal items displayed.  There is room to store mobility aids and wheelchairs where applicable. Staff and residents informed there was sufficient space in each room with the main challenge being that residents may shift other people’s belongings. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available, and residents were observed engaging in both structured and unstructured activities in these areas throughout the audit. A dining area for each wing (Barrington and Stanbury) has their own servery coming off the kitchen. Lounge areas are spacious and enable easy access for residents and staff. There are two smaller sitting areas, which provide residents with opportunities to access areas for privacy, if required or desired. Furniture is appropriate to the setting and the residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Bed linen and towels are laundered off-site by a contracted laundry provider. Personal laundry is undertaken on-site in a dedicated laundry. Care staff assist with the laundry, especially the night shift; although most is undertaken by the cleaning staff during the morning shift. All cleaning and care staff undertake training in relation to infection control and chemical handling for laundry processes. During interviews, staff described the dirty/clean flow and precautions for handling of soiled linen. Most family members were satisfied with laundry processes and although they said that clothes sometimes go missing and are found elsewhere, they volunteered this may not be the fault of staff.  There is a small designated cleaning team in each wing and all cleaning staff have received appropriate training. Chemicals were stored in a lockable cupboard in the laundry and were in appropriately labelled containers.  Duty lists for cleaning and laundry processes were sighted. These are monitored through the internal audit programme and the cleaning staff informed that they receive consistently good feedback. No cleaning and laundry corrective actions requiring followed up were evident in the internal audit records. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Easy reference flip charts are also available. Staff training records showed that emergency management is covered during new staff orientation and annually thereafter. Procedures to be followed in the event of a fire are also covered as is specific fire warden training when applicable. The current fire evacuation plan was approved by the New Zealand Fire Service on 6 June 2006. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 2 May 2019. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs were sighted and meet the Ministry of Civil Defence and Emergency Management recommendations for the Canterbury region. The maintenance person described the various water storage systems around the facility. Emergency lighting is regularly tested.  Call bells are available to alert staff when assistance is required, and the system is checked six-monthly. There was minimal use of call bells during the audit.  Appropriate security arrangements are in place. External doors are locked at a predetermined time according to the season. All windows have a security latch and all doors exiting the two wings, and for areas that require securing for safety reasons, have numeric code lock on them. Closed circuit cameras monitor public areas and are visible on a screen in the manager’s office. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows with security latches. Doors off hallways and lounge areas open onto outside garden or courtyard areas.  Heating in hallways and communal areas is via heat pump units, while each resident’s room has a wall mounted electric convection heater. Areas were warm and well ventilated throughout the audit. Families confirmed the facilities are maintained at a comfortable temperature throughout the year. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | PA Low | Somerfield provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the CM. The infection control programme however has not been reviewed annually and this requires attention.  The clinical co-ordinator is the interim infection control nurse coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the FM and tabled at the quality/risk meeting. Infection control statistics are entered in the organisation’s database and benchmarked within the organisation’s other facilities. The organisation’s senior management team is informed of any IPC concern.  Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has appropriate skills, knowledge and qualifications for the role, however, is only in this role in the interim until the new clinical manager is oriented and trained in IPC. The ICC has undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in respiratory infections.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing and increasing fluids. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident’s clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  The ICC and FM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation’s infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group’s other aged care providers.  An outbreak of a respiratory infection occurred in June 2019. Evidence was sighted of notifications to Public Health, CDHB, and restrictions around visiting, admissions and transfers. A comprehensive review of management strategies was undertaken. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator, who is currently the senior registered nurse coordinator provides support and oversight for enabler and restraint management in the wider Golden Healthcare Group services, which include Somerfield House.  The restraint coordinator confirmed staff reports that there are no enablers or restraints in use at this facility and no-one could recall the last use of a restraint at Somerfield. Staff were able to accurately describe the voluntary nature of an enabler and stated that as all residents have a level of dementia, they are unlikely to use any form of an enabler in this facility. They informed their strategies of keeping residents occupied, redirection, distraction and seeking assistance when needed is currently precluding any use of restraints and that residents are able to do what they like, when they like and if they like within reason and within the confines of the environment.  As noted above, the prospective purchaser is already a provider of rest home-including dementia services, therefore is already aware of their responsibilities around restraint minimisation and safe practice, including the requirements for staff to complete relevant unit standards. This was confirmed during interview with the prospective provider. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 3.1.3  The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | Infection related reports are reviewed, trended and analysed monthly. They are reported to staff and RNs at handovers and at staff and RN meetings. Any required actions at the time are implemented. Data is reported to quality and risk meetings two monthly. The infection control programme is evidenced to have been reviewed annually in February 2016, however no documentation is sighted of a review since then, and there is minimal evidence of a yearly analysis occurring of the previous twelve months data. This was verified by observation, documentation and interviews.  A review of ICP practices during a respiratory outbreak in June 2019, was undertaken, with no corrective actions identified. | The infection control programme is not being reviewed annually. | Provide evidence the infection control programme is reviewed annually.  90 days |

# 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.

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End of the report.