Heritage Lifecare Limited - Carter House

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Carter House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 19 January 2021 End date: 20 January 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 64

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

Carter House provides rest home, hospital and dementia level care for up to 65 residents. The service is operated by Heritage Lifecare Limited and managed by a care home and village manager and a clinical services manager. Since the last audit the clinical services manager has recently changed and HealthCERT has been notified. Residents and families spoke positively about the care provided.

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

This audit identified no areas requiring improvement.

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.		Standards applicable to this service fully attained.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

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

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

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

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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

As a Heritage Lifecare Limited (HLL) facility, Carter House is guided by the organisation's business and quality and risk management plans. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents. Staff work across all services and all staff who work in the dementia care service have completed the appropriate training.

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

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 and family.

Residents' needs are assessed by qualified personnel 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.

Medicines are safely managed and administered by competent staff.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

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

Carter House meets the needs of residents and was clean and well maintained. The building warrant of fitness requirements have been effectively met and a verification status report was available and displayed in the meantime due to Covid 19. The service is awaiting the updated building warrant of fitness from the Western Bay of Plenty Council. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste is well managed. Staff use protective equipment and clothing. Soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

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

Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint and a restraint free environment.

One enabler was in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests.

No restraints were in use. Staff demonstrated a sound knowledge and understanding of the restraint free philosophy and enabler processes.

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.

The infection prevention and control programme, led by an experienced and trained infection control nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Carter House had developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The interviewed staff 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 was included as part of the orientation process for all staff employed and in ongoing training. This was verified in training records reviewed.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The interviewed registered nurses (RN) and caregivers understood 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. Residents in the dementia unit were admitted with the consent of the EPOAs. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented. EPOAs for residents in the dementia unit were all activated and for other residents in other units as relevant. Staff were seen obtaining consent for day to day care.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A copy of the Code and information on the Advocacy Service is given to residents during the admission process. Posters and brochures related to the Advocacy Service and the Code were displayed at the reception and on notice boards in each unit. Family/whānau and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical services manager (CSM) provided examples of the involvement of Advocacy Services in relation to coordination of residents' meetings. A representative from the health and disability commissioner has provided education on advocacy services to the residents.
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/whānau 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' family/whānau and friends. Family members/whānau 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 organisation's complaints policy and complaints forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints register is maintained electronically by the care home and village manager (CH&VM). The complaints register reviewed showed nine complaints, eight of which had been addressed and closed out effectively and one complaint recently received and followed-up has been responded to and a corrective action plan implemented. There has been one health and disability complaint received in 2018 which has been closed out in November 2019. Accurate records were maintained. No other external complaints were received.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code was displayed at the reception and on notice boards in each unit together with information on advocacy services, how to make a complaint and feedback forms.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff maintained privacy during provision of personal cares throughout the audit. All residents have a private room. Residents were encouraged to maintain their independence by attending to community activities and participation in clubs of their choosing. Care plans 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 occurred during orientation and annually.
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	Staff support residents in the service 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. There was a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice was available and is supported by staff who identify as Māori in the facility. Residents who identify as Māori and their whānau reported that staff acknowledge and respect their individual cultural needs.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents and families/whānau or enduring power of attorney (EPOA) were consulted on residents' individual culture, values and beliefs. This and that staff respected these was verified in interviews conducted. Residents' personal preferences required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs were being met.

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family/whānau interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses had records of completion of the required training on professional boundaries. There are policies and procedures to guide staff. Interviewed staff demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice team, diabetes nurse specialist, wound care specialist, psycho-geriatrician and mental health services for older persons, and regular education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included access to online training programmes for staff.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The reviewed documents evidenced that family/whānau and EPOAs were informed about any changes to their relative's status. Families/whānau and EPOA confirmed that they were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code. Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English; staff able to provide interpretation as and when needed; the use of family members and communication cards for those with communication difficulties.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	Heritage Lifecare (BPA) Limited (HLL) have a standard business plan template which Carter House uses to identify site specific objectives and these are linked to the quality plan objectives. The HLL documents describe annual and longer term objectives and Carter House manager's report against these. A sample of weekly and monthly reports were reviewed which go to support office and are monitored/reviewed by the regional operations manager and the quality team. The reports sighted showed adequate information to monitor performance is reported including financial performance, health and safety compliance, occupancy, staffing, emerging risks and clinical issues.

consumers.		The service has been managed for the past two years by the CH&VM who is a registered nurse with extensive sector experience. The CH&VM is supported by the newly appointed clinical services manager who has worked at this facility for 20 years (HealthCERT were notified of this newly appointed role on the day of the audit). Responsibilities and accountabilities are defined in a job description and individual employment agreement. The regional quality manager present at the audit, the CH&VM and clinical services manager confirmed knowledge of the sector, regulatory and reporting requirements when interviewed. All have attended ongoing education through the DHB and sector organisational study days. The facility holds contracts with Bay of Plenty District Health Board for aged related residential care including hospital medical, hospital-geriatric, rest home, respite and dementia care. On the day of audit 64 residents were residing at Carter House with 17 residents receiving services within the dementia unit, 19 residents were rest home level care and 28 residents receiving hospital level care. No residents were receiving respite care or hospital medical.
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	When the CH&VM is absent, the clinical services manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the regional quality manager who reports to the regional operations manager. Both are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes audit activities, a document control system, management of incidents and complaints, a regular resident and family satisfaction survey, monitoring of outcomes, clinical incident monitoring including infections, falls, pressure injuries, skin tears, weight loss and medication errors. The organisation is committed to continuous quality improvement and clearly outlines the key elements of the quality programme in place and reviewed. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the combined staff, quality, infection control, health and safety and restraint free meeting. Staff reported their involvement in quality and risk management activities through, meeting attendance, incident reporting, hazard identification and audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are

		required to be completed annually and regular feedback is provided to managers by the residents, visitors and family/whānau. Managers reported that actions are taken in response to any feedback as appropriate. Surveys are performed as required by HLL in November and May each year. A new system was trialled in November and results available 12 January were mostly positive and a corrective action plan reflected two areas identified for improvement. Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The regional quality manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The CH & VM is familiar with the Health and Safety at Work Act (2015). The health and safety staff representative reported that she has attended appropriate training and the organisation has implemented all requirements. The hazard and risk register is maintained and updated as needed.
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 an incident/ accident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported via the organisation's central system managed by the clinical and quality team. The CH & VM manager and the regional quality manager described essential notification reporting requirements, including for pressure injuries and that these are escalated to the head of quality and clinical at support office who is responsible for ensuring notifications occur. They advised there have been five notifications of significant events made to the Ministry of Health, since the previous audit including notification to HealthCERT of the newly appointed clinical service manager as per (1.2.2).
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. An electronic system is used for the recruitment process and includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of eight staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation requires the completion of orientation and competency workbooks which include all necessary components relevant to the role. Staff reported that the orientation process prepared them well for

requirements of legislation.		their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period. The CH & VM is responsible for ensuring the staff records are maintained. Continuing education is planned on an annual basis, including mandatory training requirements. All RNs, maintenance and activities staff are required to have first aid training and staff interviewed reported they have completed the training. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The clinical services manager interviewed is the assessor for the education programme. Staff working in the dementia care area have completed the required education being one enrolled nurse (EN) and eight of nine registered nurses have completed dementia training. Twenty-six (26) of 31 care givers have completed dementia training. Twelve (12) care staff have completed level three, seven level four, seven level two, five are enrolled and seven are not enrolled yet into the programme for level three and four. All but two care staff have yet to complete the dementia training. All level three and four caregivers have completed medication competencies annually. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion 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	HLL provides a documented process which is implemented at Carter House for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, and the clinical service manager reported she lives in close proximity to the facility. Staff reported that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family/whānau interviewed supported this. Observations and review of four weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage at all times. There are six RNs who are interRAI trained and assessed as competent.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and	FA	Residents' information was paper based for most assessments and care plans except for interRAI assessments that were electronically recorded. 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. This includes interRAI assessment information entered into the momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Time and dates were documented. Archived records were held securely on site and were readily retrievable using a cataloguing system.

accessible when required.		Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. There were destruction bins for confidential information that were locked and kept in a safe place in the care home.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter Carter House when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. This was verified in the records reviewed. Prospective residents and/or their families/whānau are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The service seeks updated information from NASC and GP for residents accessing respite care. The residents in the dementia unit were admitted with the consent of the EPOAs. The sighted admission agreements were signed by the EPOAs. Family/whānau interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The nursing team with support from the GP manages the exit, discharge or transfer in a planned and co-ordinated manner, with an escort provided as appropriate. The service uses the DHBs '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/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed that adequate information was provided, and the organisation's policies and procedures were followed. Family of the resident reported being kept well informed during the transfer of their relative. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	FA	Carter House has a current medication management policy that identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. There is a safe electronic medication management system. The RN was observed administering medicines to residents and they demonstrated good knowledge, clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines had current medication administration competencies. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The supplied medication packs are checked by an RN against the prescription and documented on the electronic

guidelines.		medication management system. All medications sighted in the medication storage room and the medication trolleys were within current use by dates. Appropriate monitoring systems were implemented for eye drops and eardrops in use. Clinical pharmacist input is provided on request. Medicines were stored safely in locked trolleys in locked medication storage rooms. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Appropriate prescribing practices including the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines was evidenced on the electronic medication charts reviewed. The required three-monthly medication reviews were consistently recorded on the medicine chart. Standing orders are not used. There was one resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. Self-medication administration assessment and consent forms were completed, and three-monthly competency assessments were completed. Medication errors were monitored and comprehensive processes for analysis were implemented.
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 cook and the kitchen team 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 within the last two years. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The main cook is responsible for all food procurement. Since the last audit the organisation has an engaged external contractor who provides special diet like pureed meals and fortified food. The service operates with an approved food safety plan and registration issued by the ministry of primary industries. Food temperatures, including for high risk items, are monitored appropriately, and recorded as part of the plan. The food main cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment and diet profile were completed for each resident on admission. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit always have access to food and fluids to meet their nutritional needs. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given enough time to eat their meal in an

		unhurried fashion and those requiring assistance had this provided.
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	The CSM reported that if a referral is received 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/whānau are supported to find an appropriate care alternative. A record of enquiries was maintained and follow up was completed where required.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Validated nursing assessment tools such as pain scale, falls risk, pressure risk, nutritional screening, continence and oral health oral screening were used to identify and document any deficits and to inform care planning. The reviewed care plans had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families/whānau confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The care plans reviewed were individualised and reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Behaviour management plans were completed for residents in the dementia unit. The care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required 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	FA	Interventions in the reviewed documentation, observations and interviews with residents, family/whānau and staff verified that care provided to residents 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 interviewed GP verified that medical input was sought in a timely manner that medical orders were followed, and care was provided promptly. The caregivers confirmed that care was provided as outlined

services in order to meet their assessed needs and desired outcomes.		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.
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	There are two trained diversional therapists, two activities coordinators ad one volunteer who provide the activities programme. The activities programme in the rest home and hospital wings are run by the activities personnel Mondays to Fridays and resident initiated on Saturday and Sunday. Activities in the dementia unit are run by the activities personnel every day of the week. The activities are held in each unit separately, but residents are allowed to attend to activities in other units if they wish to do so. The residents' needs, interests, abilities, and social requirements were assessed on admission using a social history and assessment form. Activities on the programme is regularly reviewed by the activities team and the care home and village manager monthly to help formulate an activities programme that is meaningful to the residents. The resident's activity needs and plans are evaluated six-monthly as part of the formal six-monthly care plan review. Activities on the programme reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through regular residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme satisfactory. Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes pamper sessions, watering plants, walks in the secure gardens, outside entertainment, van outings and outdoor sweeping.
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 caregivers. Changes noted were reported to the RN. This was verified in the residents' files reviewed. Formal care plan evaluations were completed every six months following the six-monthly interRAI reassessment, or as residents' needs change. Where progress was different from expected, the service responded by initiating changes to the plan of care. Short-term care plans were being consistently reviewed and progress evaluated as clinically indicated. The sighted short care plans sighted were for acute infections, wounds, and unintentional weight loss. Unresolved short-term problems were added to the long-term care plan. Residents and families/whānau /EPOAs were involved in six-monthly multi-disciplinary review meetings. Residents and families/whānau/EPOA interviewed confirmed their involvement in evaluation of progress and any resulting changes.

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', 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 to specialist services were sighted in residents' files reviewed. The resident and the family/whānau were kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals were attended to immediately, such as sending the resident to accident and emergency in an ambulance as detected by the circumstances. Where the needs of a resident changed and they were no longer suitable for the services offered, a referral for reassessment to the NASC was made and a new placement found, in consultation with the resident and whānau/family.
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 HLL documented processes for the management of waste and infectious and hazardous substances. 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 and personal protective equipment (PPE) resources were available where chemicals are used and staff interviewed knew what to do should any chemical spill/event occur. Any bulk chemicals purchased are stored in a caged area within a locked and well sign- posted shed. A maintenance programme and monthly environmental checks are completed. The maintenance coordinator was interviewed and all records were reviewed. Staff interviewed understood who to ring if afterhours or urgent assistance is required. Contact details were accessible. All waste is recycled and collected by the preferred contracted service on a regular basis. Medical waste is collected as needed as is the yellow sharps containers used by the nursing staff for syringes. The contracted pharmacy collects and arranges the disposal of these items. There is provision and availability of protective clothing and equipment for all aspects of service delivery and staff were observed using this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical	FA	A current building warrant of fitness expiry date 29 November 2020 is publicly displayed. Correspondence from Fire Security Services – specified system status report evidences the specified systems are currently performing to the performance standard stated in the compliance schedule as at 26 November 2020. A form 12A was unable to be issued due to restrictions in force under the Covid-19 alert levels preventing the following scheduled inspection, maintenance and reporting procedures of the compliance schedule from being

environment and facilities that are fit for their purpose.		carried out: March & April, - monthly inspections as this was not an essential service under lockdown Level 3 & level 4. 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 including the van hoist, is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Residents were safe and independence is promoted. External areas are safely maintained and are appropriate to the resident groups and setting, with multiple easy access doors. Staff confirmed they know the processes they should follow if any repairs or maintenance is required and any requests are appropriately actioned. Residents were happy with the environment.
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 Carter House for the 64 residents on the day of audit. The dementia unit has two showers and four toilets. All rooms have a hand basin in all service areas. The rest home wing has eight rooms with ensuite bathrooms inclusive of a shower and toilet and two communal bathrooms. In addition to this there are four communal toilets. In the hospital there are three ensuite rooms and 13 shared bathrooms shower/toilet, two separate showers and one separate toilet. Separate staff and visitor toilets are available. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/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	Adequate personal space is provided to allow Carter House staff and residents to move around within their bedrooms safely. All bedrooms provide single accommodation. There are no designated shared rooms. All 40 dual purpose rooms have adequate door width and room size as required for hospital level rooms. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, hoists, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.

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 in-door and out-doors for residents to engage in activities. The dining and lounge areas are particularly spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required in their own rooms, the whānau room and/or the garden. Furniture is appropriate to the setting and 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	Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff, housekeeping staff and caregivers demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Certificates are displayed for education undertaken by staff. A contracted service provider ensures adequate stocks of laundry and cleaning products are available at all times. Regular checks of all equipment is monitored for safety. Safety data sheets are accessible in both the laundry and cleaning utility room. Residents and family/whānau interviewed reported the laundry is managed well and their clothes are returned in a timely manner. There is a small designated cleaning team who have received appropriate training. Cleaning chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored regularly by the CH&VM from residents, family and staff feedback and through internal audit activity.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	HLL provides policies and guidelines for emergency planning, preparation and response for each facility to use in the development of site-specific plans. Instructions are displayed and known to staff. HLL disaster and civil defence planning guides direct facilities in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 28 February 2001. A trial evacuation takes place six-monthly with an external expert providing oversight and feedback, the most recent being on 16 December 2020. The orientation programme includes fire and security training. 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 requirements for the 64 residents. Emergency water meets

		the requirements of the Western Bay of Plenty Council. Water storage containers are changed regularly and emergency lighting is regularly tested. Call bells alert staff through an electronic system to residents requiring assistance. Call bells are positioned throughout the facility in all rooms and communal areas and residents and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time depending on the season and staff do security checks at night. Night patrols are done in the area by a contracted security company several times a night and visits are recorded. New signage has been provided to alert residents, staff and visitors to the facility regarding the closed-circuit television (CCTV) security in place. Sensor lights are installed externally around the facility for safety purposes.
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 individual residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and external windows that open to the outside. Heating is provided in the residents' rooms and communal areas by gas heaters. Heat pumps are located in the nurse's stations and the offices. Areas were being cooled as needed on the day of audit. Residents and families/whānau confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Carter House has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from expert services. The infection control programme and manual are reviewed annually. A registered nurse is the designated IPC nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CSM and tabled at the quality and risk committee meeting. This committee includes the CSM, the care home and village manager, IPC nurse, the health and safety officer, and representatives from food services and household management. There was signage at the main entrance to the facility that 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 responsibilities. There was a COVID-19 pandemic plan in place and current information on infection control measures and

		contact tracing requirements were implemented.
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 IPC nurse has appropriate knowledge and qualifications for the role, and has been in this role for a year. The IPC nurse has completed infection prevention and control study days and online training, as verified in training records sighted. Additional support and information are accessed from the CSM, infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. Adequate resources to support the programme and any outbreak of an infection was sighted on the days of the audit. The infection control programme was last reviewed in October 2020.
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 infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2020 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. Hand washing and sanitiser dispensers were 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	Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by the CSM and other suitably qualified personnel. 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 was evidence that additional staff education has been provided in response. Additional education was provided to all staff and residents during the COVID-19 pandemic period.

		Education with residents is on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC nurse reviews all reported infections and these were documented. New infections and any required management plans were discussed at handover, to ensure early intervention occurred. Monthly surveillance data was collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. Graphs were produced that identify trends for the current year, and comparisons against the previous month and year and this is reported to the clinical services manager, IPC committee and quality team at the organisation's head office. Data is benchmarked internally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. There was no infection outbreak reported since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	HLL policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. Restraint use has been eliminated at Carter House with alternatives being explored and used instead. Managers stated the facility has been restraint free for two months and they gave examples of measures taken to ensure resident safety without the use of restraint for people unable to consent to the use of an enabler. The restraint coordinator role is performed by a registered nurse who provides support and oversight for enabler use and maintenance of a restraint free facility. The RN has been in this role for seven years and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities. All RNs are required to be restraint competent and evidence of this was in staff records reviewed. On the day of audit, no residents were using restraints and one resident was using a bedrail as an enabler. This was used voluntarily at the request of the resident. A similar process is followed for the use of enablers at Carter House that is described in HLL policy for restraint use. This was evident on review of the residents' files, and from interviews with managers and staff. The enabler use has been regularly reviewed for the resident using the bedrail, as required by HLL policy and the enabler register included documented goals for the resident concerned.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.