

Northbridge Lifecare Trust - Northbridge Lifecare Trust Rest Home & Hospital

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:	Northbridge Lifecare Trust
Premises audited:	Northbridge Lifecare Trust Rest Home & Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 23 February 2021 End date: 24 February 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:	95



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

Northbridge Lifecare Trust - Northbridge Lifecare Trust Rest Home & Hospital – provides rest home, secure dementia, and geriatric hospital care for up to 96 residents.

Since the last audit, a new care facility manager, a new clinical manager, human resources manager, and a training co-ordinator have been appointed. There have not been any changes to the services 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, managers, staff, the director, and a general practitioner.

The audit has resulted in seven areas for improvement identified. These relate to analysis of incidents/accidents, orientation, staff appraisals, staffing, noting when care plans are updated, body protection certification, and monitoring residents during restraint.

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.
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Residents and families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents.

The residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The service has linkages with a range of specialist health care providers in the community.

Information on the complaints process is readily available to residents. There have been no external complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation's philosophy, mission and vision statement and goals are documented. The care facility manager, the clinical manager, and the other members of the management team work together.

The quality management systems included incident/accident reporting, complaints/compliments, health and safety meetings, identifying the organisation's risk, resident and staff satisfaction surveys, restraint minimisation, monitoring of restraint and enabler use, and infection control data collection. Quality and risk management activities and results are shared amongst the management team and staff. Corrective action planning is occurring. Policies and procedures are available for staff reference.

New staff are provided with a general orientation. Staff participate in relevant ongoing education, which includes some competency assessments. Applicable staff and contractors have a current annual practising certificate. There is always at least one registered nurse on duty. Staff working in the secure dementia unit for more than 18 months have completed an industry approved qualification in dementia care.

Residents' information is kept securely with all entries legible and designated.

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.		Some standards applicable to this service partially attained and of low risk.
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Policies and procedures provide documented guidelines for access to service. Residents are assessed prior to entry to the service to confirm their level of care. The registered nurses are responsible for assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs and routines. Interventions are appropriate and evaluated in a timely manner. A physiotherapist and occupational therapist are employed by the organisation on a part-time basis and are involved in the care-plan process.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activities are conducted separately in the hospital, rest home and memory care centre, respectively.

There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioners and these were current. Staff involved in medication administration are assessed as competent to do so.

The food service provides and caters for residents. Specific dietary likes and dislikes are identified. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours.

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.		Some standards applicable to this service partially attained and of low risk.
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Waste and hazardous substances are well managed. Staff have available and use appropriate protective equipment and clothing. The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment is tested as required. Clinical equipment has undergone clinical calibration and performance monitoring checks. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Chemicals, hazardous substances, and equipment are safely stored. Laundry is undertaken onsite. Cleaning and laundry services are 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. Appropriate call bells are available.

Security is appropriately maintained. Security cameras are in use.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Four enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Five residents had restraints in use. An appropriate assessment, and approval process was in place. The need for the use of restraints is regular reviewed. Staff demonstrated knowledge and understanding of the restraint 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.
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The infection control management system minimises the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Infection data is collated monthly, analysed, and reported during staff meetings.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service and is carried out as specified in the infection control programme.

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	44	0	3	3	0	0
Criteria	0	94	0	3	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Northbridge Lifecare Trust has policies and procedures to meet their obligation 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 and ongoing training was verified in the training records. The last training was held on 28 January 2021. The Code is displayed around the facility and provided to residents and family/whānau as part of the admission process.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled verified that informed consent had been gained appropriately using the organisation's standard consent form. These are signed by competent residents, or the enduring power of attorney (EPOA). The general practitioner makes a clinically based decision on resuscitation authorisation of residents deemed not competent. Sampled files evidenced signed resuscitation decisions and advanced directives by residents who are deemed competent.</p> <p>The CM reported that verbal consent was sought on admission about sharing of rooms from residents</p>

		<p>who are competent to make decisions and EPOAs respectively.</p> <p>Staff were observed to gain consent for day-to-day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents were aware of the advocacy service, how to access this and their right to have support persons. The CFM and staff provided examples of the involvement of advocacy services in relation to residents' care.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Family/whanau or friends are encouraged to visit or call.</p> <p>The facility has unrestricted visiting hours (unless restrictions required due to the current Covid-19 pandemic national alert level) and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Northbridge Lifecare Trust (NLT) implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family members, the managers and staff reported their understanding of the complaints process and this aligns with the policy. Template forms and a drop box are available near the main entrance of the facility so residents and family members can provide feedback or make a complaint at any time.</p> <p>A complaints register is maintained by the care facility manager (CFM) who is responsible for the complaint's management processes. There have been nine complaints received in the last 14 months. There have been no complaints received from the Health and Disability Commissioner, Ministry of Health, or District Health Board since the last audit as reported by the director, CFM and clinical manager during interview.</p> <p>Staff interviewed confirmed they would bring any resident or family member's concerns to the attention of the management team or the registered nurse on duty. Residents and family members interviewed confirmed they were aware of the complaints process. A review four complaints verified the service acknowledges, investigates, and responded to complaints in a timely manner. The CFM is aware of the requirements and timeframes for responding to complaints as required by the Code. One new complaint</p>

		<p>was open at audit.</p> <p>Staff were provided with training in January 2020 on dealing with complaints effectively. This was attended by 25 staff.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English languages. Family members and residents interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process.</p> <p>The admission pack outlines the services provided. Resident agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There is a policy and procedure regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms and reporting requirements. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice.</p> <p>Residents' privacy and dignity are respected. Staff were observed maintaining privacy. A contracted physiotherapist (PT) visits weekly to conduct the physiotherapy programme with help from the physiotherapy assistant. Residents are supported to maintain their independence with residents assessed as rest home, hospital, and dementia level of care. Residents from the rest home and hospital areas were able to move freely into the surrounding areas and in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and</p>	FA	<p>Assessments and care plans document any cultural and spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. There were no residents who identified as Maori and cultural needs would be considered when required. There were two staff members of Maori descent. Policies and procedures regarding the recognition of Maori values and beliefs are documented.</p>

acknowledges their individual and cultural, values and beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Cultural needs are identified on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the resident and family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents confirmed they were encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans reviewed.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Residents interviewed reiterated the same. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. A code of conduct statement is included in the staff employment agreement. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The care facility manager (CFM) stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed promptness and appropriateness of medical intervention when medical requests are sought.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. The organisation supports nursing student placements from the local training institutes. There is a training coordinator who provides ongoing training for staff. Many of staff have level three and level four industry approved qualification.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were normally 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 sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures Personal, health and medical information is collected to facilitate the effective care of residents.</p> <p>There were no residents who required the services of an interpreter however staff knew how to access</p>

communication.		interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The care facility manager has developed a business plan for the hospital, rest home and memory care centre for 2021. This was distributed to staff for feedback on 12 January 2021. The organisation's goals are identified. The mission and eight guiding principles for the organisation are also documented, including in information provided to new employees. There is an annual strategic planning process. Work is also underway on a master plan to replace the care facility building in stages, starting late 2022 or 2023 as the care home facility is now 42 years old. The director advised a key consideration in the design process will be ensuring the facility is fit for purpose in the event of a pandemic.</p> <p>The NLT care facility manager has a master's degree in health service management (Massey University), and is a psychologist and has worked in management roles in rehabilitation / disability services. She started work in the CFM role on 5 October 2020. The care facility manager has oversight of services with the support of the clinical manager. The CFM was provided with a two-week orientation by the previous manager.</p> <p>The clinical manager has been in this role since May 2020 and prior to this worked in NLT in a registered nurse role for approximately three years. The previous clinical manager resigned from the role at the end of April 2020, and currently works as the training coordinator (16 hours a fortnight commencing 12 January 2021), and also works casual registered nurse (RN) shifts. The previous clinical manager confirms being available to mentor and support the current clinical manager as required.</p> <p>In addition, the management team includes the human resources manager (a new role since the last audit), the works manager (responsible for the facility and has been in the role approximately 10 years), the catering manager and the director. The director has worked in the aged related residential care (ARCC) and village sector for over 25 years and has been at NLT in a director role for approximately eight years. The director reports to the Northbridge Lifecare Trust board of trustees (BOT) monthly. There are eight members of the BOT and this includes the chairperson of the village resident committee who is a member of the BOT while in this role for up to two years.</p> <p>The care facility manager has exceeded eight hours of education per annum related to managing an aged related residential care facility as required by the providers contract with Auckland District Health Board (ADHB). The clinical manager also participates in relevant ongoing education.</p> <p>The CFM formally reports to the director monthly via a written report and meets with the director weekly or sooner if there are issues. The director also attends management meetings with the other management team members.</p> <p>There is a manager on call and there is a RN or CM on-call afterhours for clinical matters. The persons</p>

		<p>responsible are documented on the roster.</p> <p>The facility has an Aged Related Residential Care Contract (ARRC) with ADHB for the provision of rest home, secure dementia, and continuing hospital level care. There were 95 residents receiving care at the time of audit. This included 38 residents at rest home level of care, 42 residents at ARRC continuing (hospital) level of care, and 15 residents in the secure memory care centre (MCC). Seven beds can be used for either rest home or hospital level care.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the CFM's absence, the clinical manager is responsible for the oversight of care and services provided with the support of the director. The charge nurse undertakes the clinical manager's role in the clinical manager's absence. The charge nurse is a long-standing RN at NLT</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>Northbridge Lifecare Trust has a quality and risk management system which is understood and implemented by service providers. This includes satisfaction surveys, incident and accident reporting, health and safety/hazard reporting, infection control data collection and management, and concerns/complaints management.</p> <p>There is an internal audit programme that details a range of audits to be completed each month and template forms are available for conducting each of these audits. The care facility manager and clinical manager were initially unaware of the schedule or availability of template documents until these were located during audit. The CM has however undertaken a number of 'spot checks' doing an observation review of an aspect of practice, for example, that there are current photographs of every resident as part of the medicine record, or checking if staff are signing for and wearing a pager when on duty and the results were documented and communicated to staff. An audit of the hairdressing services was conducted by another staff member in December 2020 using the applicable template audit form. An external consultant also undertook a review of the NLT services against the health and disability services standard in November 2020 and provided feedback to the service. A moving on 'audit action plan' had been completed for audits sighted or the corrective actions required were listed at the end of the document or meeting minutes.</p> <p>Northbridge Lifecare Trust provides opportunity for residents to complete a resident response survey for new admissions. Some completed forms were sighted. Questions include ascertaining if the residents</p>

		<p>were given information on the Code of Rights, complaints process, advocacy services, orientation to the facility, and first impressions. The CFM recently met with residents via way of holding two 'listening clinics' to obtain feedback directly from residents about any topic the residents wanted to talk about at the end of January 2021. Concerns about the food were the main issues raised in the meeting summaries sighted.</p> <p>Policies and procedures are available to guide staff practice. The care facility manager is responsible for ensuring policies are updated according to a schedule with input from the management team and other applicable staff. There are three paper copies of policy and procedure manuals available to staff. Electronic archiving of updated policies is occurring. All policies and procedures were current or in the process of being reviewed. Staff interviewed confirmed they can access required policies easily and were informed when policy documents have been updated. Requested policies and procedures were sighted during audit. An administrator is responsible for document control processes. Staff are provided with updates on new policies or changes to existing policy.</p> <p>Actual and potential business risks are identified in the NLT business risk management plan. This document was developed by the care facility manager and is dated 27 January 2021. The CFM advises this document and the care facility's ongoing operational/business risks will be regularly reviewed with input from the CM and discussed at the continuous quality improvement meetings. Resident specific risks are evaluated by registered nurses during interRAI assessment and care plan reviews.</p> <p>The health and safety committee meets monthly with representative from all services and the village. Minutes are available for staff. A staff exercise programme has been initiated. Staff working in an area are responsible for notifying hazards and this may be via a maintenance request. The organisation's hazard/risk register is in the health and safety manual.</p> <p>The continuous quality improvement (CQI) meeting has been held two monthly since October 2020 and is attended by the care facility manager, clinical manager, infection prevention and control nurse, health information manager and an external quality advisor, as able. The minutes of various staff meetings including the registered nurse meeting, health and safety meeting, and household staff meetings are discussed for any meetings that have occurred. The CFM noted she is looking to reconvene the caregiver and household staff meetings for 2021. The CQI meeting also includes discussion on the infection surveillance data, data and document control, complaints/concerns and compliments use of restraints and enablers and numbers of adverse events reported, and education provided to staff. Incident/accident data is being evaluated in a consistent and timely manner. This is an area requiring improvement.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	<p>FA</p>	<p>Policy and procedure detail the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme.</p>

<p>untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Applicable events have been reported. Staff identifying the event are required to report this to the RN on duty who is responsible for investigating the events and initiating required changes in care. Sampled events have been disclosed with the resident and/or designated next of kin. This was verified by residents and family members interviewed with one exception, and records of communications maintained in the sampled residents' files or on the incident records. The RN on duty is responsible for contacting the family. Completed forms are sent to the CM for review and signoff. Two designated staff are allocated the responsibility for maintaining a register of all reported events and the totals per month, the care area and type of event and providing this to the clinical manager. Staff confirm applicable events are discussed at shift handover.</p> <p>There is an event register for the memory care centre and rest home and one for the hospital. While the number and category of events per month is recorded, there is inconsistent evaluation of the data and timeliness of this. This is raised as an area for improvement in criterion 1.2.3.6.</p> <p>A review of reported events, for four sampled residents (rest home, hospital, and memory care centre resident) including witnessed and unwitnessed falls with and without injury, skin injuries, medicine error, and a resident absconding demonstrated that incident reports are completed, investigated and responded to in a timely manner.</p> <p>The care facility manager, the director and the clinical manager advised there have been essential notifications made to the Ministry of Health and/or District Health Board since the last audit related to the changes in clinical manager, and the care facility manager, and a short period of time an RN was not available on site as contractually required on 31 December 2020. A notification was also made to public health services in relation to a norovirus outbreak in November 2020. The CM also notified the DHB of a resident that absconded on two occasions and was subsequently reassessed as requiring secure dementia level care. The management team could identify the other types of events that require external notification.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The human resources manager (a new role since the last audit) assists with facilitating recruitment and human resource processes. All recruitment related records are now held by the HR manager. Previously some records were also held by the previous CFM. With the merging of the information from two sources there was substantial duplication of documents in the sampled staff files. The HR manager advised the service is working to transition from having paper based human resource (HR) records to an electronic record and will address duplication issues as part of this process.</p> <p>The recruitment process included completing an application form, interview, and referee checks. The job description was present in all except two staff files. One staff member has worked at NLT for over 10 years and the other transitioned from a contractor. Employment contracts were present in sampled files.</p>

		<p>Police vetting of clinical staff has occurred or in in process for all except one staff member. This staff member is a long-standing employee. This is not raised as an area for improvement as the current system supports these processes to occur.</p> <p>All employed and contracted registered health professionals (RHPs) have a current annual practising certificate (APC). The CM has been monitoring the annual practising certificates for registered nurses and had records verifying this. A folder with the APC data for contracted staff was in the CFM office. Some of the data was initially out of date including the APC for two of the GPs, the pharmacists, and the physiotherapist. The CM advised he will take responsibility for monitoring this data moving forward and has included these contracted health professionals in his ongoing APC monitoring process. All contracted and employed health professionals were subsequently verified as having a current annual practising certificate during the audit.</p> <p>All staff advise they are provided with an orientation relevant to their roles, however, records are not retained to demonstrate any role specific orientation undertaken. Bureau staff are also reported to be provide with an orientation and there is a folder of information that is to be discussed. Records are not retained to demonstrate this orientation is occurring and that all applicable components are included.</p> <p>A comprehensive staff education programme is in place with in-service education records retained. This includes some competency assessments. Staff are supported to complete an industry approved qualification.</p> <p>The annual performance appraisals for some staff are overdue.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Moderate</p>	<p>There is always a registered nurse on duty in the hospital unit. Staff are encouraged to complete an industry approved qualification and are rostered to work in allocated units. There is an allocation process for each shift identifying which staff are responsible for the care of identified residents. Staff working in the memory care centre have an industry approved qualification in dementia care as required to meet ARRC contractual requirements.</p> <p>Some residents report their call bells are not answered in a timely manner; call bell logs identify some residents are waiting over eight minutes for their call bell to be answered. The roster allocates a registered nurse or enrolled nurse to be on duty in the rest home most morning shifts. However, over an 11-day period prior to this audit there was only one day where a RN or EN actually worked the scheduled shift. It is reported that instead these shifts are covered by an HCA or HCA team leader. This does not allow for the contractual requirements specified in D17.3 e) relating specifically to registered nurse requirements to be met. The registered nurses at interview stated they needed more support. The staffing policy requires review and updating.</p>

		There are six RNS that have interRAI competency.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>There is a new electronic record management system in place. Residents' records are held both electronically and paper based. Staff have individual passwords to the residents' records data base, such as the medication management system and on the interRAI assessment tool. The visiting GPs and allied health providers also have access to the system which supports integration of residents' records.</p> <p>Some residents' records are maintained in hard copy. This includes the admission agreement, consent agreements and the current care plan. All hard copies are kept securely in the locked cupboards. Hard copy archived records are stored safely and securely on site. There is an effective system for retrieving both hard copy and electronically stored residents' records.</p> <p>All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Completed Needs Assessment and Service Coordination (NASC) authorisation forms for the memory care centre, rest home and hospital level of care residents were sighted. Residents in the memory care centre were admitted with consent from EPOAs and documents sighted verified that EPOAs consented referrals to specialist services. Files sampled evidenced that all residents were assessed by specialists and confirmed current level of care.</p> <p>Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Indications for use are noted for 'as required' medications, allergies are clearly indicated, and photos were current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. The medication and associated documentation are in place. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from hospital or any external appointments. The RNs check medicines against the prescription, and these were updated on the pharmacy delivery forms. The GPs completes three monthly reviews.</p> <p>There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal were reported and attended to promptly. Monitoring of medication room temperature was maintained. The RNs were observed administering medications safely and correctly. Medications were stored in a safe and secure way in the trollies and locked storerooms. Medication competencies were completed annually for all staff administering medication. The CM reported that some medication related audits are conducted.</p> <p>There were no residents self-administering medications. There is a policy and procedure for self-administration of medication if required. Weekly and six-monthly controlled drug stock takes were conducted. Outcomes of pro re nata (PRN) were documented in the progress notes.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is an approved food plan for the service which expires 16 June 2022. The food service is managed by the catering manager. There are three employed chefs assisted by four kitchen assistants. Meal services are prepared on site and served in the allocated dining rooms. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. There is a five-weekly rotating winter and summer menu in place. The menu was reviewed by the registered dietitian in October 2020 to confirm it is appropriate to the nutritional needs of the residents.</p> <p>The residents have a diet profile developed on admission which identifies dietary requirements, likes, and dislikes and is communicated to the kitchen including any recent changes made. Nine out of eleven residents interviewed were not satisfied with the evening meals, and these concerns were being followed up by the catering manager and CFM. Residents participate in meals services through diary communication. Diets are modified as required and the catering manager confirmed awareness of dietary needs of the residents. The family members interviewed expressed satisfaction with the food service.</p> <p>The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night.</p>

		The kitchen and pantry were sighted and observed to be clean, tidy, and well stocked. Labels and dates were on all containers. Records of food temperature monitoring, fridges and freezers temperatures were maintained. Regular cleaning is conducted. Staff who work in the kitchen have all received the relevant in-house training.
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 CFM reported that all potential residents who are declined entry are recorded and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The person/family is referred to the referral agency to ensure the person will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents have their level of care identified through the needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' care plans and interRAI are completed within three weeks, according to policy. Assessments and care plans are detailed and included input from the family/whanau, residents, and other health team members as appropriate. Additional assessments were completed according to the need (e.g., behavioural, nutritional, continence, and skin and pressure risk assessments). The RNs utilises standardised risk assessment tools on admission. In interviews conducted, family/whanau and residents expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment findings and input from resident and/or family/whanau, informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans were used for short-term needs. Residents in the memory care centre had twenty-four-hour activities care plans in place. Behaviour management plans were implemented as required. Family/whanau and residents confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapist, occupational therapist, district nurses, dietitian, and GP.

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders carried out. The CM reported that the GPs' medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person centred. This was confirmed by the GP during interview. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by three diversional therapists (DTs), three activities assistants (AAs) and a recently recruited occupational therapists from Monday to Sunday in all residents' respective units. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. A hairdresser is on site weekly. There is a gym and library area that residents can use if desired. A life memoir is completed for each resident within two weeks of admission in consultation with the family.</p> <p>The activity programme is formulated by the activities staff. The activities are varied and appropriate for people living with dementia, rest home and hospital level of care. The activities team leader compiles a monthly report which is presented to the CFM and in quality staff meetings. Residents' activities care plans were evaluated, however the new electronic record management system in place does not identify the exact dates these were developed following the interRAI assessments (refer 1.3.3.3).</p> <p>Twenty-four-hour activity plans reflect residents' preferred activities of choice and are evaluated every six months or as necessary. Activity progress notes and activity attendance checklists are completed daily. The residents were observed participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family members reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is documented on each shift by care staff in the progress notes. All noted changes by the health care assistants are reported to the nursing team in a timely manner.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals, occurs every six months or sooner if residents' needs change. However, the current electronic information management system in place cannot identify when the care plan was developed following interRAI assessments (Refer 1.3.3.3). The evaluations are carried out by the RNs in conjunction with family, residents, GPs', and specialist service providers. Where progress is</p>

		<p>different from expected, the service responded by initiating changes to the care plan.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent service is indicated or requested, the GPs and the nursing team refers to specialist service providers and the DHB. Referrals are followed up on a regular basis by the GPs and CM. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. The cleaning, and laundry staff interviewed confirmed they have completed training in the safe handling of chemicals. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of appropriate protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>A current building warrant of fitness was publicly displayed. Clinical equipment was calibrated. The body protection certificates are out of date.</p> <p>External areas were safely maintained and appropriate to the resident groups and setting. There is a secure appropriate garden area accessible to residents living in the memory care centre (a secure unit).</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they were happy with the environment.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes toilets and showers that are for general resident use, and bathroom ensuites, some of which are shared between two bedrooms. There are designated bathroom facilities available for staff and for visitors. The ablutions in the memory care centre (secure dementia level of care) were safe with no accessible chemicals, and afforded privacy. There is a large bathroom that has a shower tray insitu in the hospital unit.</p> <p>Hot water temperature monitoring of the water outlets accessible to residents recommenced at the end of January 2021. Hot water temperatures were not recorded for the period March 2019 to January 2021. The records sighted showed the temperatures are at or below 45 degrees Celsius.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' safety and independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. In the memory care centre, all the bedrooms are single occupancy with an ensuite. All the bedrooms in the rest home except one room are single occupancy. One room (rm 14) can have a couple in the room, although was single occupancy at audit. In the hospital wing there are four rooms that have four beds in the room and fifteen single occupancy rooms. There are appropriate privacy curtains around bed spaces.</p> <p>Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids and wheelchairs. Staff and most residents reported their bedrooms are suitable for their needs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. The kitchenette servery area in the memory care centre was secured to prevent unauthorised access for confused people. Residents can access other areas for relaxation/privacy, in all areas of the home if required. Furniture is appropriate to the setting and residents' needs. There is a hairdressing salon on site, and a physiotherapy room/gym.</p> <p>The quiet room is used for the provision of end-of-life care. There is a kitchenette, lounge area, call bells and an ensuite. This room is spacious facilitating family members being able to stay to provide the resident with support.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site seven days a week by employed staff. Staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported their clothes are normally returned in a timely manner.</p> <p>There are designated cleaners who are responsible for allocated areas. There is a task list in each unit detailing the activities to be completed, frequency and products to be used.</p> <p>Each member of the household team has attended suitable training, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. These areas were observed as clean and staff were vigilant with ensuring cleaning chemicals or equipment were not left unattended. Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Flip-card guides 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 19 November 2007 (EVAC 00655-07). A trial evacuation takes place six-monthly (except due to Covid -19 lockdown) with a copy of the evacuation report sent to the New Zealand Fire Service. The most recent fire drill occurred on the 20th of November 2020.</p> <p>The orientation programme includes fire and security training. Staff in all areas including the memory care centre, confirmed their awareness of the emergency procedures. Each individual resident's required level of assistance is noted in the resident's care plan. The emergency documents identified residents in the memory care centre require 'extra supervision'.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, clinical and other consumables, blankets, and for cooking were sighted and meet the requirements for the maximum number of residents (96) and the water storage requirements for the region. There are water tanks available. The works manager advised these contain a total of 55,000 litres of drinkable water located on site for the entire premises (care home and village). There is additional water supply for use in the garden.</p> <p>A generator is in place. The works manager advised this can provided power 24/7 for all whole care home facility. The generators functioning is tested monthly by a contractor and diesel stocks kept full.</p> <p>Call bells alert staff to residents requiring assistance, and to alert staff in the event of an emergency event. These alert to staff pagers as well as a light illuminating outside the applicable room and onto a centralised alert panel. Residents reported on occasions there are delays by staff in responding promptly to call bells. This is included in the area for improvement raised in criterion 1.2.8.1. The CFM and works</p>

		<p>manager advised a text alert is sent to the CHM and CM if the call bell has not been answered within 12 minutes.</p> <p>Appropriate security arrangements are in place. There are security cameras monitoring internal communal areas and entry points. Signage alerts that these cameras are in use. Doors and windows are locked by staff at a predetermined time. Images are retained for a designated period and are accessible only to the works manager. Staff in the memory care centre wear pendant staff duress alarms. An external security company is contracted to undertake regular security checks through the complex each night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. All bedrooms have natural light and opening external windows. Heating is provided via electricity / radiator panels or heat pumps in residents' rooms and communal areas. The works manager advised the temperatures of the radiators is controlled centrally for safety. Areas were at an appropriate temperature and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature all year round.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>There is a documented infection prevention and control programme. The programme is reviewed annually. The review includes a review of the last year's annual infection control data, plus training, infection prevention and control audits and policies and procedures. The review is completed by the infection prevention and control coordinator (ICC), CM, learning and training coordinator and the report is shared with staff, CQI and in management meetings. The RN is the ICC and has been in this role for four months. The position description details the responsibilities for this role.</p> <p>Exposure to infection is prevented in several ways. The organisation provides relevant training, there were adequate supplies of personal protective equipment (PPE) and hand sanitisers. Hand washing audits were completed, the required policies and procedures are documented, and staff are advised to not attend work if they are unwell. Flu vaccines are offered to all staff and residents.</p> <p>There was a pandemic outbreak plan in place. Information and resources to support staff in managing COVID-19 was regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by the MOH were documented. There was an infection outbreak in November 2020 which was managed according to policy. The facility was closed to the public for a week, with GPs family/whanau, residents, and relevant authorities notified in a timely manner. Documented evidence of staff and residents affected was sighted.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The RN is responsible for implementing the infection control programme and indicated there are adequate people, physical, and information resources to implement the programme. Infection control reports are discussed at management and staff meetings. The ICC has access to all relevant residents' data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory, learning and training coordinator and the attending GPs.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The service has documented policies and procedures in place that reflect current best practice. Policies and procedures are accessible and available for staff in all three nurses' stations. These were last reviewed in November 2020. Staff were observed to be following the infection control policies and procedures. 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. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Staff training on infection prevention and control are routinely provided during orientation and annual in-service education. In-service education is conducted by either the RN or learning and training coordinator. The following training was provided in 2020: hand washing procedure; infection prevention and control; and regular Covid-19 related updates. Records of staff education were maintained.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control</p>	FA	<p>The surveillance programme is defined and appropriate to the size and scope of the service. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Results of the surveillance data is shared with staff during shift handovers, at monthly staff meetings or RN, CQI and management meetings. Evidence of completed infection control audits were sighted.</p> <p>Staff interviewed confirmed that they are informed of infection rates as they occur. The GPs were</p>

programme.		informed in a timely manner when a resident had an infection and appropriate antibiotics were prescribed for all diagnosed infections.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator who was appointed to the role in December 2020, provides support and oversight for enabler and restraint management in the facility. The restraint coordinator is supported by the clinical manager and confirmed the position's role and responsibilities are documented, and have been made clear.</p> <p>On the day of audit, five residents were using restraints (padded bedrails and/or a bucket chair) and four residents were using enablers (bedrails), which were the least restrictive and used voluntarily at their request. The files of three residents with restraint in use and one resident with enablers in use were reviewed.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the CQI meeting minutes, files reviewed, and from interviews with the restraint coordinator, clinical manager, and staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval group, made up of the clinical manager and restraint coordinator, are responsible for the approval of the use of restraints and the restraint process. It was evident from review of residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Two family members of a resident with restraint in use (bedrails) were interviewed and verified they were consulted prior to restraint use and are involved with the ongoing assessment and review processes. Use of a restraint or an enabler is documented where applicable in the residents plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. An RN undertakes the initial assessment with the restraint coordinators or clinical manager involvement, and input from the resident's family/whānau/EPOA. The RN interviewed/restraint coordinator described the documented process. Family involvement was evident as consent forms have been signed. Ongoing use is discussed when interRAI assessments and care plans are updated and also discussed where applicable during the annual multidisciplinary review. Two family members verified these processes. The</p>

		<p>general practitioner is consulted about the use of the restraint if there are any concerns.</p> <p>The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives, and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of three residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Moderate</p>	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (e.g., the use of sensor mats, low beds, and distraction/diversion).</p> <p>When restraints are in use, frequent monitoring is required to ensure the resident remains safe. Records of monitoring were incomplete for some shifts in the three sampled files and this is an area requiring improvement.</p> <p>A restraint register is maintained, updated every month and reviewed at the CQI meeting. The register was reviewed and contained all residents currently using a restraint and enough information to provide an auditable record. In addition, the CM reports monthly to the CFM on the use of restraints and enablers.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use. Staff were provided with training on restraint minimisation and safe practice on 4 February 2021. Twenty-two staff completed this training. In addition, the training focus for February is on caring for residents with dementia and managing challenging behaviours. At least 29 staff have completed this training with other staff in the process of completing a series of modules online.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the CQI meetings. Family members input into decision making and the evaluation process was confirmed.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p> <p>Two family members of a resident with restraint in use (bedrails) were interviewed and verified they were involved in the review process.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>A six-monthly review of all restraint use is undertaken during interRAI assessment or re-assessment and during care plan reviews. This includes assessing resident outcomes, and any associated adverse events. The CM and restraint coordinator advised restraint is used for the shortest period necessary and discontinued when no longer applicable. A resident has had restraints in use for just under a month and another for seven days respectively.</p> <p>In addition, there is an annual restraint and enabler audit undertaken that evaluates the other components required to meet this standard. This audit is due to be next completed before the end of February 2021. The February 2020 audit results were sighted.</p> <p>The use of restraint is reported to the CHM monthly and to the CQI meeting which is currently meeting every 2nd month. The use of restraint is also discussed at other applicable staff meetings. The restraint policy is presented at the CQI meeting when due for review. The current policy is noted as due for review in June 2022.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Incidents and accidents are reported by staff and these are categorised and totalled and reported monthly. For some month, the clinical manager reviews and evaluates this data and reports on the contributing factors and system prevention measures that are required. However, this is not consistently occurring as verified during interview with the clinical manager. Reports were sighted dated October 2020 analysing July 2020 incident data and a report dated 7 February 2021 evaluated October 2020 data.</p> <p>Infection surveillance data and the use of restraints and enablers are being monitored and reported on.</p>	<p>There is reporting of adverse events and incidents and these are totalled and reported monthly. There is not always evidence of timely analysis of this information.</p>	<p>Ensure adverse events and incident data is analysed in a timely manner and the results communicated to staff.</p> <p>180 days</p>

<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Moderate</p>	<p>All staff are provided with an orientation. This is undertaken by the clinical manager and includes the NLT mission, philosophy, roster/allocation, teamwork, care guidelines, call bells, incident and accident reporting, process for staff injuries and illness, documentation, confidentiality, uniforms, taking breaks and residents. A record is retained demonstrating this orientation has occurred. While staff report they are provided with an orientation that is relevant to their role and responsibilities, records are not retained to demonstrate what is included in this and who provided the training. Role specific orientation records were not present in any of the staff personnel records sampled and formal documentation is not in use as verified by interview with the HR manager and the CM.</p> <p>Bureau staff are involved with the provision of resident care. There is a folder than contains the key information that is required to be discussed with bureau nurse by the RN on duty prior to their first shift. Records are not available to demonstrate that bureau staff are provided with all applicable information.</p>	<p>Staff interviewed advised they are provided with an orientation relevant to their role and responsibilities. However, the content of any role specific orientation activities/programmes have not been documented.</p> <p>Bureau staff are provided with an orientation. Records are not retained to demonstrate this has occurred or the content.</p>	<p>Develop and implement an orientation programme that details the orientation topics new staff are required to complete as relevant to their different roles and responsibilities. Maintain records to demonstrate that staff are being provided with orientation relevant to their roles.</p> <p>Document the information that is required to be discussed with new bureau staff prior to their first shift. Maintain records to demonstrate that this orientation is consistently occurring.</p>

				90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>A comprehensive staff education programme is in place with in-service education identified and opportunities and topics are provided every month. Northbridge Lifecare Trust have purchased the rights to an online education programme appropriate to the ARRC sector and to meet contractual requirements with ADHB. Staff are advised of the education topic for the month and given an email with information on how to access this training. In addition to this, the training coordinator undertakes some in-person group sessions covering this information for staff who are unable to complete this on-line for any reason. Records of attendance are being maintained for education provided.</p> <p>There is a clinical competency programme. This includes first aid (for all RN, the enrolled nurse (EN), HCA team leaders (TL)), manual handling for all clinical staff, medicine competency (RNs, EN and health care assistant (HCA) team leaders), syringe driver competency and male catheterisation for the registered nurses. Records of completion are maintained by the clinical manager on an electric spreadsheet. The CM has been working to ensure staff have current manual handling competencies with regular training provided by the physiotherapists. Most staff have completed this requirement. The registered nurses have a current first aid certificate, syringe driver competency and male catheterisation competency. The HCA team leaders have full current medicine</p>	<p>Despite initiatives taken by the management team to address this issue, some staff are overdue performance appraisals.</p>	<p>Undertake annual performance appraisals for all staff.</p> <p>90 days</p>

		<p>competency that includes theory and practical component (a total of 23 staff with full medicine competency) and 17 HCA's have completed the competency as a second checker of medicines.</p> <p>Care staff are encouraged to complete a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. In the summary document provided, eighteen staff have completed a level two industry approved qualification. Eleven staff have completed a level three industry approved qualification or have equivalency. Nineteen staff have completed a level four industry approved qualification or have equivalency. At least 23 staff have completed an industry approved qualification in dementia care, and two are currently completing this training. All staff employed more than 18 months and who work in the secure dementia unit have completed an industry approved qualification in dementia care. The CFM is an approved assessor, and the training coordinator is in the final stages of completing assessor training and competency requirements.</p> <p>An annual performance appraisal is required for all staff. Despite initiatives taken by the management team to address this issue, some staff are overdue performance appraisals. In the electronic appraisal register sighted (a document shared by the CM and CFM), details of the last or next appraisal due date had not been identified for at least 43 staff. Thirteen staff were noted as overdue appraisals by 300 or more days.</p>		
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<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>A human resource policy includes information on staffing rationale and skill mix. Rationale will include residents' needs assessment, clinical indicators/outcomes, fluctuations in demand and meeting contractual obligations. It notes that experienced HCAs are employed where able. The organisation's staffing policy does not include any guidance on staffing when care staff attend callouts for village residents.</p> <p>Some staff are rostered set shifts. Others are rostered flexible rotating shifts. Staff are rostered to work in the hospital, or rest home or memory care centre.</p> <p>There is always at least one RN on duty 24 hours a day seven days a week in the hospital wing. The hospital, rest home and memory care centre are within the same building and accessible internally. A review of the roster shows the care home manager and clinical manager work weekdays. The care facility manager or clinical manager is on call when not on site. If the CM is not on call another experienced RN is noted on call.</p> <p>The rosters for the hospital, and rest home/memory care centre were reviewed for the 19 January 2021 to 15 March 2021 (two four-week rosters).</p> <p>HOSPITAL: In the two rosters sighted two RN's or a RN and a EN have worked on a morning duty or are rostered for future shifts in the Hospital for clinical or office-based duties with up to seven exceptions each</p>	<p>1. The organisation's staffing policy does not include any guidance on staffing when care home staff attend callouts for village residents.</p> <p>2. There are two lines titled 'team leader RN/EN/Senior HCA' on the rest home morning shift roster, and the qualification of the person filling the shift is not easily identifiable at first glance. Registered health professionals and non-regulated care staff have different responsibilities and accountabilities.</p> <p>3. There are 15 occasions between 23 January and 17th February 2021 where the RN or EN rostered shift in the rest home was instead worked by an HCA including four weekend shifts. This resulted in only one RN eight-hour shift worked during an eleven-day period (25 January to 4 February 2021) in the rest home, with the CM and hospital based RN's assisting the HCA staff as and if required. Intermittent RN/EN interaction with residents in the rest home and memory care unit is not sufficient to meet the contractual requirements relating to the RN oversight, guidance and training responsibilities as required by the ARRC contract clause D17.3 e iii-</p>	<p>1. Review staffing and skill mix to ensure adequate registered nurse oversight in the rest home and memory care unit in order to meet aged related residential care contractual requirements.</p> <p>2. Review the layout of the rest home / memory care centre roster to ensure it clearly identifies the qualifications and accountabilities of the staff member filling the shift leader role.</p> <p>3. Monitor staff response timeframes for answering call bells and</p>

		<p>roster when an extra HCA or HCA team leader are rostered or have worked. There are up to five days each roster when there are three RN's/EN who have worked or are rostered to work on a morning duty with one of these RN's allocated office-based time.</p> <p>There are up to eight other HCAs in the morning and five HCAs in the afternoon (with some variation in rostered hours), plus two additional staff assisting residents with the dinner meal. There are three HCAs overnight.</p> <p>REST HOME: In the rest home on the roster 16 February to 15 March 2021 there is a RN or an EN rostered or working daily on the morning shift except for four days. The layout of the rest home /memory care centre roster needs review for clarity. There are two lines titled 'team leader RN/EN/Senior HCA', and the qualification of the person filling the shift is not easily identifiable at first glance. The rest home RN/EN also covers the memory care centre.</p> <p>On the roster sighted for 19th January to 15th February there were 13 morning shifts where the RN or EN rostered on duty in the rest home did not work and was replaced by either an HCA or HCA TL. This resulted in only one dedicated RN eight-hour shift worked in the rest home during an eleven-day period (25 January to 4 February 2021 inclusive) in the rest home. The CM and other RNs reported assisting HCA staff if requested/required. The CM was onsite except two of these days (on the weekend).</p> <p>The registered nurses interviewed reported they need more RN support. Some staff</p>	<p>vi. The registered nurses interviewed reported they need more RN support.</p> <p>4. Seven out of 11 residents interviewed advised their bells are not answered in a timely manner (predominantly residents living in the rest home area) and this was further verified by review of call bell answer times data.</p> <p>5. There is no formal process to regularly evaluate the call bell timeframe response data.</p>	<p>address any variances.</p> <p>4. Update the staffing and skill mix policy and include the requirements, processes and monitoring for when care staff attend village call outs.</p> <p>90 days</p>
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		<p>commented that the CM was working very long hours. Some HCAs interviewed noted the RNs were often busy doing 'paperwork'.</p> <p>In addition to the RN or HCAs working in the rest home as detailed above, there are five other HCAs in the morning and four in the afternoon with variable start or finish times, and two HCAs overnight.</p> <p>MEMORY CARE CENTRE: There are three HCA staff rostered in the morning and three in the afternoon (working variable hours), and one HCA overnight.</p> <p>OVERALL: there is a minimum of one RN and six HCAs on duty across the care home.</p> <p>The registered nurses attempt to complete office-based activities between 11 am and 2 pm unless required for clinical care.</p> <p>Afterhours 5 pm to 8 am, care facility HCA staff attend village residents who activate their call bell. Two HCA's always attend the call out (delegated by the RN) and stay with the resident until the issue has been addressed. The RN does not leave the hospital. The CM is monitoring the number of occasions that HCA staff attend call outs but not the duration of time staff are away from their designated unit. There were six and seven call outs to the village in November and December 2020 respectively, and none in January 2021.</p> <p>There are rostered hours for designated staff for cleaning, laundry, activities/diversional therapy, physiotherapy assistance, and administration. Staff noted they normally could complete the required tasks in the allocated time frames. There is a</p>		
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		<p>physiotherapist on site weekdays (20 hours a week) and an occupational therapist for eight hours a week.</p> <p>Seven out of 11 residents interviewed advised their bells are not answered in a timely manner (in particular residents living in the rest home area), although family did not raise any concerns. There is the ability to obtain detailed call bells reports. There is no formal process to regularly evaluate the call bell data, which can provide objective information on resident response timeframes. There is a high volume of resident calls. The call bell data sighted during audit identified that 132 call bells were not answered within an eight-minute timeframe during the period 1-23 February 2021. Seventy five percent of these call bells were answered within nine to 16 minutes and twenty five percent of these call bells were answered between 16 and 25 minutes.</p> <p>Bureau staff are used. The clinical manager reports monthly on this. In November and December, four to five RN shifts (hospital) and between 20 and 42 HCA bureau shifts (hospital and rest home) were utilised. The clinical manager and HR manager advised recruitment of HCAs was undertaken to address the HCA staffing issues and by January bureau use was reduced significantly.</p> <p>The HR manager advised there is a casual RN vacancy and for two HCA's (one is a full-time position) being recruited.</p>		
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<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>InterRAI assessments and service delivery plans were completed within three weeks of admission by the nursing team. Subsequent reviews of long-term care plans and activity plans were completed; however, the electronic system does not indicate when they were reviewed. Assessments and care plans are completed by the CM, RNs, diversional therapy (DT), physiotherapist, occupational therapist and care staff involved in the review process. This was confirmed by family/whanau and residents in interviews conducted. Evidence of this was sighted in the 10 residents' files reviewed.</p>	<p>The electronic record management system does not identify when the care-plan has been reviewed.</p>	<p>Ensure the electronic record management system identifies exact dates when care plans are reviewed.</p> <p>180 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>A current building warrant of fitness (expiry 18 November 2021) was publicly displayed.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained, except for the body protection certificates displayed in the hospital wing which were noted as being due for review in September 2011. Interviews with the works manager (who is responsible for the maintenance personnel) verified these is overdue. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, as well as observation of the environment. The environment was hazard free, residents were safe, and independence was promoted in all areas including the memory care centre.</p> <p>The facility vehicle has a current registration</p>	<p>The body protection certificates in the hospital wing are dated as due 17 September 2011.</p>	<p>Ensure body protection certification is maintained.</p> <p>180 days</p>

		and warrant of fitness and this is monitored regularly.		
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	<p>PA Moderate</p>	<p>When restraints are in use, frequent monitoring if required to ensure the resident remains safe. Records of monitoring was incomplete in the three sampled files. There were entire shifts that were blank on the monitoring forms and on other occasions staff had noted they had checked the resident but had not detailed what interventions if any were provided (e.g., repositioning, offering food and fluids, or hygiene care).</p> <p>Access to advocacy is provided if requested and all processes ensure dignity and privacy are respected.</p> <p>The CM gave an example about discontinuing the use of restraint when a resident attempted to climb over a bedrail. The resident was instead placed the same day on a low low bed with bean bags on the floor to reduce the resident's risks.</p>	<p>The monitoring records for residents with restraints in use are poorly completed in three out of three applicable residents' records sampled.</p>	<p>Ensure staff monitor residents with restraints in use at the frequency required by the organisation and appropriate records are available to demonstrate this is occurring.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.