

# Heritage Lifecare (BPA) Limited - Riverside Care Home and Hospital

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Heritage Lifecare (BPA) Limited
<b>Premises audited:</b>	Riverside Care Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
<b>Dates of audit:</b>	Start date: 15 April 2021    End date: 16 April 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	63



# Executive summary of the audit

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## 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
Yellow	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
Red	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

Riverside Lifecare provides rest home, dementia and hospital level care for up to 65 residents. The service extended its scope to include residential-physical disability care two years ago, but there have been no admissions under this level of care since.

The service is operated by Heritage Lifecare Limited (HLL) and managed by a care home/facility manager and clinical services manager.

The only change within the service since the previous certification audit in 2019 is the appointment of a new clinical services manager.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the District Health Board (DHB). The audit process included review of documents including residents' and staff files, observations and interviews with residents, family members, managers, staff, and a general practitioner (GP).

Residents and their families spoke positively about the care provided.

## 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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Implemented systems and the environment is conducive to effective communication. The complaints management system meets the requirements of the Code and is known by staff, residents and their families. There have been no serious complaint investigations since the January 2019 certification audit. Families reported that staff immediately respond to and begin to address any concerns they raise.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the national support office is regular and effective. Experienced and suitably qualified people manage the services being delivered.

The quality and risk management system includes monitoring service delivery and other operations against key performance indicators. Quality improvement data is collected and benchmarked nationally. Outcomes are analysed for trends and lead to improvements. Staff are involved, and feedback is sought from residents and families.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. These were in the processes of being reviewed and those audited were current.

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

Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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On admission to Riverside Lifecare, residents' have their needs assessed within the required timeframes by the multidisciplinary team. Shift handovers, communication sheets and stable staffing guide continuity of care.

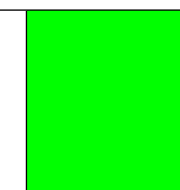
Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is overseen by a diversional therapist and two activities staff. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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


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

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There have been no changes to the structure of the buildings since the previous audit. Building improvements for safety and enhancements are ongoing. There is a current building warrant of fitness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint processes adhere to the required standard. On the days of audit there was one resident in the hospital with a restraint intervention in place and one resident in the rest home using enablers (bed rails) voluntarily to assist them with positioning in bed.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken. Data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

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	16	0	0	0	0	0
Criteria	0	40	0	0	0	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns.</p> <p>The complaints register contained six complaints received in the past year and there were no known complaints to the office of the Health and Disability Commissioner. Records and interview with the manager revealed that a letter of acknowledgement, ongoing communication and investigations into the matter had been completed within acceptable timeframes. One complaint was still open at the time of this audit; this is being followed up by the organisation's national office.</p> <p>The manager is responsible for complaints management and follow up, with support from the regional operations manager if the matter is serious or complex. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status and were advised in a timely manner about any incidents or accidents. Communication about the outcomes of, and invitations to participate in regular or urgent medical reviews were forthcoming. This was supported in the residents' records reviewed. Staff and the managers interviewed understood the</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services are available when required. At the time of the audit there were no residents for whom English was a second language.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business plan 2020-2021 outlines the purpose, values, scope, direction and objectives of the organisation and is reviewed annually. The manager, quality coordinator and clinical services manager also develop site specific objectives which link with the quality plan objectives.</p> <p>The documents reviewed described annual and longer term objectives and the associated action plan. A sample of weekly operations reports to national office contained adequate information to monitor performance. This contains occupancy, health and safety issues, financial performance, compliments and complaints, staffing, property issues, and any other emerging risks and issues.</p> <p>The manager who oversees the day-to-day service delivery is a registered nurse who has worked at this facility for 11 years and has been in the manager role for four years. This person is supported on site by the clinical services manager, part time quality coordinator and reports up to a regional operations manager. This manager is well known locally for her expertise in aged care and maintains knowledge of the sector, regulatory and reporting requirements through attendance and representation at local forums and at conference and study days.</p> <p>The service holds contracts with the district health board (DHB) and (MoH) for hospital, rest home, younger persons with a disability (YPD), dementia and respite care services.</p> <p>Sixty-five (65) beds are available. On the day of audit, there were 63 residents. Twenty-one were assessed as rest home level care, 25 at hospital level care and 18 were receiving dementia level care. Six of these residents were under the age 65 years (YPD), four at hospital level and two at rest home level. There were no respite care residents.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>The organisation's quality and risk system reflects the principles of continuous improvement and is understood by the staff. This includes management of incidents/accidents, complaints and audit activities, an annual satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint practices.</p> <p>Terms of reference and meeting minutes sighted confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs, and related information is reported and discussed at the weekly team meetings, and quality and staff meetings held monthly.</p> <p>Minutes reviewed included discussion on pressure injuries, restraints, falls, complaints, incident/adverse</p>

<p>principles.</p>		<p>events, infections, audit results and the activities programme. Staff interviewed reported their involvement in quality and risk activities through audit activities. Any relevant corrective actions are developed and implemented as necessary to demonstrate continuous improvement is occurring. Resident and family surveys are completed annually and are sent out from the HLL support office. This includes younger people with a disability. The last survey conducted in October 2020 did not reveal any major concerns. Corrective actions related to feedback has been implemented by staff.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements and were current. The document control system is managed at HLL support office. All documents are updated as required and sent out via a memorandum with instructions for replacement in the manuals. This process ensures a systematic and regular review process, referencing of relevant resources, approval, distribution and removal of obsolete documents. Staff are updated on any new policies or changes to policies through the staff meetings and sign that they have read and understood these.</p> <p>The manager described the process for the identification, monitoring of risks and development of mitigation strategies. The service risk register showed consistent review and updating of any risks identified, risk plans and the addition of any new risks. There is a dedicated health and safety committee with staff representatives from a range of disciplines. The manager, clinical services manager, quality manager, and other health and safety team members interviewed were aware of and have attended training in the Health and Safety at Work Act (2015) requirements and have implemented requirements.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There were well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed these are reviewed and discussed at staff meetings and then trended and further evaluated at the national office for benchmarking. Avoidable events are evaluated and actions are implemented to prevent recurrence.</p> <p>Interviews and review of incident data confirmed that incidents are discussed at shift handover, and trending data is displayed in staff areas. Each resident's care record contained a summary of incidents which facilitates a ready review of risks.</p> <p>The FM in conjunction with the regional manager is responsible for essential notifications and reporting and understood the statutory and regulatory obligations. Since the previous audit in 2019, section 31 notifications have been submitted for the change in clinical services manager, challenging behaviours where police were involved, and pressure injuries assessed as above stage 3. On the days of audit there was one resident with a notifiable pressure injury related to their palliative condition.</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>FA</p>	<p>Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The staff records sampled confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed showed documentation of completed orientation and a performance review annually. New staff reported that the orientation process prepared them well for their role. Staff records showed documentation of completed orientation followed by an initial performance review after 90 days.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The in-service education schedule was sighted. Mandatory training requirements are defined and scheduled to occur over the course of the year. An education register records all staff attendance. Competencies are maintained and were recorded on the competency register reviewed. Care staff have completed the required education to meet the requirements of the provider's agreement with the DHB. Education records reviewed demonstrated completion of the required training.</p> <p>Eight of eleven registered nurses have completed and are competent to perform interRAI assessments. Time is allocated to the staff for completing the required assessments. The care staff working in the dementia service are all qualified to work in this service having completed the approved dementia care levels of training required.</p> <p>Training to meet the needs of younger individuals with disabilities also occurs.</p> <p>Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs and to review competencies. Each of the staff files sampled contained evidence of annual performance appraisals.</p> <p>All care staff are expected to commence age care sector training (as outlined in their pay equity settlement) three months after commencing employment if they do not already have qualifications. The manager and quality coordinator are authorised moderators of the education programme provided on site. On the days of audit, 23 of the 30 carers had completed the Limited Career Pathway-dementia module, nine had achieved level 4 of the National Certificate in Health and Wellness, 16 had completed level 3 and five were at level 2.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery 24 hours a day, seven days a week (24/7).</p> <p>The organisation (HLL) uses 'allocation of staff/duty rosters', an electronic tool based on indicators for safe staffing, and this is used by the care home manager and the clinical services manager when preparing the</p>

<p>from suitably qualified/skilled and/or experienced service providers.</p>		<p>rosters. The manager is able to adjust staffing levels to meet the changing needs of residents. An after-hours on call roster is in place with staff reporting that good access to advice is available when needed. The care home manager and the clinical services manager are on call seven days a week.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and families interviewed supported this.</p> <p>The rosters reviewed confirmed adequate staff cover has been provided with staff replaced in unplanned absences. There are registered nurses on every shift in all areas of service delivery except on the night duty where there is one registered nurse supported by three caregivers across all services.</p> <p>The clinical services manager and the care home manager work Monday to Friday. Adequate care staff cover the facility on all shifts with various 'short shifts' being available to provide additional support at the busy times across the twenty-four-hour period. Staff interviewed commented that any emergency situations are managed effectively.</p> <p>All staff have completed first aid courses and certificates were in the staff records reviewed. There are 11 registered nurses including the clinical services manager and care home manager. All have competencies for medication management, verification of death, wound care management, female and male catheterisation and other medical and palliative care management roles.</p>
<p><b>Standard 1.3.12: Medicine Management</b></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 is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the</p>

		<p>commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who had requested to self-administer medications at Riverside at the time of audit. There are appropriate procedures to guide staff when a resident wishes to self-medicate.</p> <p>Medication errors are reported to registered nurse (RN) and clinical services manager (CSM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Riverside.</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>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu was reviewed by a qualified dietitian on the 15 January 2021. Recommendations made at that time have been implemented.</p> <p>An up-to-date food control plan is in place and was audited by Food Safety Quality and Labelling New Zealand (FSQLNZ) on 8 December 2020. The audit identified two areas requiring corrective action and these have been attended to. The food control plan has been verified for twelve months.</p> <p>A review of kitchen identified all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Modified textured food is available and purchased by Riverside from an external provider. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Residents in the secure unit, have access to food anytime of the day and night. The unit has a kitchen area in the dining room. Every day the unit orders food from the main kitchen to be provided to enable residents needs over the next 24-hours to be met. Observation evidences a wide range of food available in the unit.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident's interviews following residents eating the main meal. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to</p>

		residents as needed.
<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>	FA	<p>Documentation, observations, and interviews verified the care provided to residents of Riverside was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision, for example, wound care management, pressure injury management, behaviour management, post falls assessment and management. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</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>	FA	<p>The activities programme is provided by one trained diversional therapist and two activities staff.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal three/six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included walks, a daily exercise programme visiting entertainers, quiz sessions, pamper sessions, cooking, cards, 'housie', van outings and daily news updates.</p> <p>The activities programme is discussed at the regular family afternoon teas for residents in the secure unit. Residents in the secure unit have a 24-hour activity plan in their file.</p> <p>Residents' meetings in the hospital and rest home have recently recommenced following Covid-19 restrictions. Meetings minutes indicated residents' input is sought and responded to. Liaisons with families during Covid-19 restrictions included phone calls, texts, newsletters, and video calls.</p> <p>Resident and family satisfaction surveys demonstrated satisfaction with the programme. Information provided as feedback is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p> <p>Residents under 65 are enabled to access a range of activities within the facility and in the community as they request and are able.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care at Riverside is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans are in place for short term problems and are consistently reviewed and evaluated as clinically indicated. Wound management plans evidence evaluation each time the dressing is changed and includes photos. Residents and residents' families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>	FA	<p>A building warrant of fitness is current and was displayed at the entrance to the facility with an expiry date of 19 December 2021.</p> <p>There have been no changes to the structure of the buildings. All buildings, plant and equipment inspected during the audit were in good condition and showed evidence of being well maintained. There have been no incidents related to the environment.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of infections at Riverside is in line with that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>RNs log all recorded infections that are identified on the shift into the resident's infection data base. The infection control co-ordinator (ICC) who is also the CSM reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality, health and safety, RN, and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>Riverside at the time of audit is managing a skin condition outbreak in one area of the facility. The outbreak has been contained and all best practice management strategies implemented. Public Health and the Taranaki District Health Board (TDHB) have been informed. A gastric outbreak in September 2020, resulted</p>



		<p>in seven residents and two staff members with gastric upsets. Public Health and the TDHB were informed. Specimens did not identify any specific cause. The duration of the outbreak was four days, and the facility was placed in isolation during that time.</p> <p>A good supply of personal protective equipment is available. Riverside has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<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 is also the care home manager/RN, provides support and oversight for enabler and restraint management in the facility. This person demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the days of audit, one resident was using a restraint and one resident was using an enabler which was the least restrictive and used in a voluntary capacity at the request of the resident.</p> <p>Restraint is only used as a last resort when all alternatives have been explored. This was clear on review of the restraint group meeting minutes, residents' records reviewed and staff interviewed.</p>

## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.