

Dunblane Lifecare Limited - Dunblane Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Dunblane Lifecare Limited

Premises audited: Dunblane Lifecare

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 7 April 2021 End date: 7 April 2021

Proposed changes to current services (if any): This provisional audit was undertaken to assess a prospective new provider's readiness to purchase and provide geriatric hospital, rest home and dementia services at Dunblane Lifecare.

Total beds occupied across all premises included in the audit on the first day of the audit: 48

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Executive summary of the audit

Introduction

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

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

General overview of the audit

Dunblane Lifecare in Gisborne provides rest home, hospital and dementia care services for up to 73 residents. The service is operated by Heritage Lifecare Limited and managed by a care home manager, who is also the clinical services manager. Residents and families spoke positively about the care provided.

This provisional audit was requested as the facility is being purchased by a different provider: New Zealand Aged Care Services Limited (NZACS). The audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. Audit processes included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, allied health providers and a nurse practitioner.

The six areas requiring improvement identified at the last audit have been addressed. There are no required improvements identified as a result of this audit. There are no concerns with the prospective provider intending to provide services at Dunblane Lifecare.

Consumer rights

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

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

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

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

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

Organisational management

New Zealand Aged Care Services Limited (NZACS) has a documented transition plan which was reviewed and discussed during interview. This provides timeframes and staged steps for processing all the matters necessary for acquiring the facility and its operations. The NZACS team demonstrated knowledge and understanding about all the requirements for delivering residential rest home care to older people under NZ legislation, the Health and Disability Services Standards and funding agreements. They plan to continue using the already established quality, risk and human resources systems in place as agreed by the current owners.

Organisational and facility focused business plans include the scope, direction, goals, values and mission statement of the organisation. Monthly reports on business plan objectives and on clinical indicators are provided to the governing body and meeting

minutes and organisational responses confirmed risks are being managed. An experienced and suitably qualified person manages the facility.

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

The appointment, orientation and management of staff are based on current accepted recruitment and appointment practices. A systematic approach to identify and deliver ongoing training supports safe service delivery. Individual performance reviews are completed annually. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

Dunblane Lifecare works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Short term care plans are developed to manage any new problems that arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Shift handovers and communication sheets guide continuity of care.

Residents and families interviewed reported being well informed, and that the care provided by Dunblane Lifecare is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and an activities assistant and 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 using an electronic system. Medications are administered by registered nurses and 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 satisfaction with meals.

Safe and appropriate environment

Dunblane Lifecare provides suitable environments for the rest home, hospital and dementia services provided. A current building warrant of fitness is on display and all equipment is being monitored. Electrical equipment checks are current and hot water temperatures are safe. Internal and external environments are safe, and repairs and maintenance are being attended to.

The management of waste and hazardous substances meets requirements. Personal protective equipment is readily available, and staff are using it appropriately.

Laundry is undertaken both on and offsite and all laundry and housekeeping duties are monitored for effectiveness. Staff receive training in the safe management of chemicals.

Staff undertake annual training in fire and emergency management and fire safety systems are reviewed. Emergency supplies including sufficient food and water are available for use in an emergency. Security systems are appropriate for this facility.

Restraint minimisation and safe practice

Restraint minimisation policies and procedures guide processes regarding restraint use. A restraint coordinator is responsible for ensuring relevant documentation is completed in a timely manner. Only approved restraints are being used and their use is reviewed through registered nurse meetings. The organisation is implementing a project on reducing the use of restraints, and this has reduced the use of restraints over recent months.

Infection prevention and control

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

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	100	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Dunblane Lifecare (Dunblane) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and ongoing annual training, as was verified in education planning and records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Eight clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record.

		<p>Staff were observed to gain consent for day-to-day care.</p> <p>In the dementia unit resident files evidenced specialist authorisation for admission. All dementia service residents have an EPOA and evidence on file that this has been activated.</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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family/whānau members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons but stated they had not felt the need for the service as staff and management were approachable and responsive to requests. Two residents interviewed, who had raised concerns, were very happy with the process and the resolution reached.</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.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family/whānau and friends. Family/whānau members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. During a recent Covid-19 lockdown staff utilised video calls to maintain connections.</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>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that there have been no complaints since the last audit in October 2020. However, review of complaints managed prior to that date showed that investigations and subsequent actions taken, through to an agreed resolution, are</p>

		documented and completed within the expected timeframes. Action plans show any appropriate follow up and improvements have been made where possible. The care home manager is responsible for complaints management and their follow up, unless the complaint is against the manager, or is from the Health and Disability Commission (HDC), in which case the support office oversees the follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit and the care home manager informed that an HDC complaint made in relation to the previous owner continues with the service providing information to the HDC as needed.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family/whānau interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided and discussion with the facility manager. The Code is displayed in each of the wings in both English and Te Reo Māori; and at the main reception together with information on advocacy services, how to make a complaint and feedback forms. The prospective provider knows and understands the consumer rights that it must adhere to.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>Residents and family/whānau members confirmed that services provided at Dunblane are done so in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit, when attending to personal cares and by ensuring resident information was held securely and privately. All residents have a private room.</p> <p>Residents are encouraged and assisted to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in activities of their choosing. Each care plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural,</p>

		<p>religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and provided on an annual basis, as was verified in training plans and records.</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 acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs; this included sharing a karakia each day.</p>
<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>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed such as food likes and dislikes. The resident interviews and satisfaction survey confirmed that individual needs are being met.</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>Residents and family/whānau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct, and all registered nurses have completed this training. 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.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Dunblane encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, physiotherapist, infection prevention and control nurse and mental health services for older persons, and education of staff. The nurse practitioner (NP) confirmed the service sought prompt and appropriate medical intervention and were responsive to medical requests.</p> <p>Staff reported they receive management support for education and the notice board in the staffroom advertised external courses that were available for staff to pursue. In-service training was held regularly. The registered nursing staff reported they also accessed online training to support good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family/whānau 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 and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed where family communication is documented. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff were able to describe how to access interpreter services, although reported this was rarely required due to staff able to provide interpretation as and when needed; the use of family members and communication cards for those with communication difficulties. The registered nurse stated that if a resident from the dementia unit had to attend appointments they were always accompanied by family/whānau or a staff member.</p>
<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</p>	FA	<p>A business plan for 2020-2021 was sighted. Five group overarching goals cover resident and staff satisfaction, finances, the provision of quality clinical care, health and safety, and property. There are</p>

<p>consumers.</p>		<p>documented business requirements and measures of success against each. Facilities add their own goals and action plans and complete the reporting template on a monthly and quarterly basis. A Heritage Lifecare document called 'The Heritage Way' includes the HLL vision of being a significant provider of aged care services throughout New Zealand especially in the area of residential care for older people. Its overall mission is: 'the continued pursuit of excellence in care through monitoring, auditing, actioning and evaluation of services whilst respecting and valuing our residents, families and staff'. The organisation's commitment and ability to achieve its mission is dependent upon its five underlying values of integrity, respect and value, commitment, effectiveness, and efficiency. A sample of monthly reports sent from the business and care manager to HLL were sighted, as were examples of the clinical indicator data provided to HLL each month. Both sets of reporting provide monitoring of financial reporting, emerging risks and issues of concern.</p> <p>The service is managed by a person in a dual role as care home manager/clinical nurse manager who holds relevant qualifications. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The care home manager has suitable experience in nursing roles and care coordination roles, which included care of the older person. Knowledge of the sector, regulatory and reporting requirements was confirmed. Ongoing professional development was evident in reports of how they maintain links with the local DHB, through Heritage Lifecare Limited conference and training opportunities.</p> <p>The service holds contracts with the District Health Board to provide rest home, hospital and dementia care services, including for respite care, for up to 73 people. On the day of audit, 17 beds were occupied in the rest home. Seventeen hospital level care residents were in the facility and 14 dementia care beds were occupied.</p> <p>An interview with one of the principals of the prospective purchasers, New Zealand Aged Care Services, was undertaken during the audit and confirmed relevant authorities had been informed of the intention to purchase. The prospective owner is well prepared to oversee the management of this facility as he/she has owned aged care facilities previously and has others they are responsible for. This person is</p>
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		<p>familiar with the Health and Disability Services Standards and the Aged Related Residential Care Agreement with DHBs. Plans in place include continuing with the policies and procedures currently in use and taking on all staff under the same terms and conditions they already have. Quality and risk systems will continue as they currently are, as will monthly reporting to the new management team. An information memorandum was supplied, as was a copy of a detailed spreadsheet outlining the transition plan. The status of each aspect of the framework is clear with dates of completion and any prioritisation for action evident, although this has been updated over time. Documentation relating to future development / business plans for Dunblane were viewed and included information that most aspects of service provision will remain the same for the foreseeable future. The plans include a philosophy that focuses on the needs of residents and family/ whānau and that high-quality care from suitably qualified and trained staff will be provided.</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>The regional operations manager provides support and advice when the care home manager is not available. HLL also has a 'roving' clinical services manager and a relief care home manager who can step in when needed. Staff interviewed stated that the current arrangements work well. The prospective provider advised that their own management team will relieve for management of business aspects in any future absences of the business and care manager.</p> <p>Other registered nurses in the team at Dunblane are able to relieve one another. During absences of the clinical nurse manager, (who in this case is also the facility manager), the clinical management is overseen by the clinical manager from another local facility. A nurse practitioner at the GP practice is also experienced in the sector and able to take responsibility for any clinical issues that may arise. The care home manager said these arrangements will be maintained under the new management except for the availability of a clinical manager from another local HLL facility. According to the prospective purchaser interviewed, and documentation provided, a clinical nurse manager employed by the new provider will be available to relieve the business and care manager. This person will also provide ongoing advice as needed.</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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, pressure injuries, falls and wounds for example.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators is occurring. Related information is reported and discussed at the quality and risk meetings, registered nurse meetings, all staff meetings and service/department meetings, all of which are held monthly. Staff reported their involvement in quality and risk management activities through assisting with internal audits, undertaking training and completing forms such as incident reports. A comprehensive organisation-wide internal audit schedule is being upheld. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey was completed online mid-2020.</p> <p>Policies and procedures reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. These are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The care home manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. This is completed with oversight and direction from the HLL support office. The business and care manager is familiar with the Health and Safety at Work Act (2015) and implements requirements accordingly through the monthly health and safety meetings, which include staff representation from all areas of the facility.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to quality and risk meetings, registered nurse meetings and all staff meetings. Corrective actions and quality improvement initiatives are developed from incidents and examples were reviewed during the tracing of incidents reviewed.</p> <p>The care home manager described essential notification reporting requirements, including for pressure injuries. Section 31 notifications had been completed for relevant and necessary events.</p> <p>Prospective provider interview:</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these.</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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes an initial interview, referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Records of APCs confirmed all registered health professionals associated with the facility have a current registration.</p> <p>Staff orientation includes all necessary components relevant to the person's specific role. According to staff interviewed, the three-day orientation timeframe may be extended depending on previous experience, or level of competence for their role. Staff reported that the orientation process prepared them well for their role but that development into the role is ongoing. Staff records reviewed show completion of orientation documentation including required competencies.</p> <p>Continuing education, including mandatory topics, is planned on an annual basis, and delivered according to an annual schedule provided by the support office. If staff have not attended at least 80% of in-service sessions, they are sent a letter and required to catch up with care home</p>

		<p>manager. Except for a few people with extenuating circumstances, care staff have either completed or commenced a New Zealand Qualification Authority education programme, or equivalent, to meet the requirements of the provider's agreement with the DHB. Staff working in the dementia care area have either completed, or are enrolled in the required education, except for two new employees. Plans to enrol these two were reported.</p> <p>Currently only one of the five registered nurses is maintaining their annual competency requirements to undertake interRAI assessments. Three additional registered nurses are booked to attend InterRAI training imminently. Additionally, the care home manager has employed two new registered nurses who are due to commence their employment within the next two weeks. Both are interRAI trained and competent.</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>	FA	<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). The care home manager reportedly discusses any concerns about the need for additional staff with other registered nurses. The care home manager, who is also a registered nurse, is on-call 24 hours a day on seven days a week, but there is the expectation that the registered nurse rostered on duty is responsible for decisions on that shift. There is 24 hour/seven days a week registered nurse coverage in the hospital. The care home manager noted her role as a registered nurse in supporting the other junior registered nurses and informed one way of managing the low number of registered nurses is to use a 12-hour registered nurse shift roster. With the employment of two further registered nurses, it is anticipated that the 12-hour shift roster will be phased out.</p> <p>Residents and family members interviewed commented on how busy the staff are, with one commenting that the weekends felt very 'quiet', but could not fault the care and support provided.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided according to the ratios supplied by the support office. Minimum numbers for each shift are documented and these have been upheld. Staff are either replaced in the event of an</p>

		<p>unplanned absence, or the length of shifts are adjusted to ensure adequate staff cover. All registered nurses and 15 other staff have a first aid certificate. This ensures each shift is covered by a trained 'first-aider'. Caregivers do the medicine administration rounds under leadership from the registered nurses. Twenty-three staff are medicine administration competent, fourteen of which are also second checkers. Medicine competent staff are also identifiable on the roster. Twenty of thirty-four health care assistants have completed qualifications that include dementia training. These people have been fully orientated to work in the dementia service and are rostered accordingly, although may also work in the rest home or hospital. The care home manager confirmed occasional shifts in the dementia unit may have one of the two staff who does not meet this requirement, but this was not evident in the four weeks of rosters reviewed.</p> <p>As noted in 1.2.1, there are no plans to change any aspect of staffing, including numbers and registered nurse cover. The prospective purchaser noted that the new clinical manager will review needs going forward to ensure the residents' needs continue to be met. As noted in 1.2.1, the policies and procedures are not expected to change in the short term and this includes those related to rostering, staffing levels and skill mix intended to ensure safe service delivery 24 hours a day, seven days a week (24/7).</p>
<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>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP, NP, and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible, with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>Residents enter Dunblane Lifecare when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their family/whānau are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The facility seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family/whānau members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p> <p>A document from a medical specialist verifying the resident requires secure dementia level of care was present in all sampled residents' files and all residents have consent for admission from their EPOA.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Taranaki District Health Board (TDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident including, recent medical notes, medication charts, contact information and a transfer form describing residents abilities and special needs. Residents from the dementia service are always escorted by a next of kin or staff member. All referrals are documented in the progress notes. An example reviewed of a resident recently transferred to the local acute care facility showed appropriate documentation accompanied the resident. Family of the resident reported being kept well informed during the transfer of their relative.</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 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. Observation of a medication round showed medications were administered in a safe manner. 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. The previous corrective action related to this is now closed.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse checks all medications against the prescription. All medications sighted were within current use by dates and the date of opening was documented for topical medications and eye drops. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP or NP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were no residents who self-administer medications at the time of audit.</p> <p>There is an implemented process for reporting and comprehensive analysis of any medication errors.</p>
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<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 four cooks and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Gisborne District Council (expires 10 December 2020). Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training as observed in staff files.</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. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The facility manager confirmed it is rare to decline and admission. However, if a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. An example of a resident being declined respite care at short notice was discussed and evidence of referral back to the NASC sighted. There is a clause in the</p>

		access agreement related to when a resident's placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information on admission is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, and nutritional screening as a means to identify any deficits and to inform care planning. The sample of eight care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Eight care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were consistent with care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff at handover. Residents and families reported participation in the development of care plans. Care plans reviewed from the dementia service had 24-hour triggers and interventions for behaviour management.</p>
<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 care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The nurse practitioner interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, she has confidence in the staff and is good. 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</p>

		residents' needs including hoists and pressure relieving devices. Those residents with specific medical conditions had action plans in place for monitoring, such as fluid balance and weight charts.
<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 two staff, a newly qualified diversional therapist and an activities assistant. The programme runs Monday to Friday and is complimented by care staff in the evenings and at the weekends using movies and music videos. The residents were observed to be engaged in activities including singing and indoor bowls on the day of audit. Residents from the dementia unit are invited out to join activities in the rest home lounge if they choose or can remain in the unit for quieter activities.</p> <p>A social profile and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly when goals are set. And six-monthly as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interesting and that there is always something to do. The facility has a van for outings; however, the number of outings has diminished due to the Covid-19 pandemic. A monthly planner details activities on offer and is visible to all residents who can choose the activities they wish to attend.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes music and entertainers as residents appear to respond well to music. Each resident in the dementia unit has a 24-hour programme specific to their abilities and preferences.</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 is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. This was verified in all resident files reviewed. Examples of short term care plan's being consistently reviewed and progress evaluated as clinically indicated were noted for infections, minor injuries such as skin tears and wound care management. The previous corrective action related to this is now closed.</p> <p>Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes and had opportunity for involvement in the six-monthly multidisciplinary meetings.</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 are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner or a nurse practitioner. If the need for other non-urgent services is indicated or requested, the GP, NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the speech language therapist and dietitian. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Infectious waste is placed into yellow bags and integrated into general waste. General waste and recyclables are disposed into skips and removed weekly by a contracted</p>

<p>substances, generated during service delivery.</p>		<p>provider. A local chemist is contracted to manage the sharps containers.</p> <p>Inspection of three sluice rooms and a chemical room, confirmed chemicals are stored safely. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Staff attendance was evident in training records and personnel files sighted. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. A spill kit is available.</p> <p>There are generous supplies of protective clothing and equipment available for staff use including plastic aprons, masks, gloves and face shields. New storage facilities for the increased bulk of PPE were being erected on the day of audit. Staff were observed using these items and making regular use of hand sanitiser. Staff were familiar with the hazard register on display in the staff room.</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>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 1 December 2021) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment, including weighing scales, is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Likewise, three monthly hot water checks are completed, wheelchair and hoist checks are up to date and regular workplace inspection checklists are being ticked off. Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted.</p> <p>Landscaped gardens are attractively maintained by two members from the local community and an employed gardener. External areas are safely maintained and are appropriate to the resident groups and setting. A safe and secure garden and courtyard sit beside the dementia unit for residents to freely move around in.</p> <p>Residents and family members confirmed that any repairs or maintenance required are appropriately actioned and that they are happy</p>

		<p>with the environment.</p> <p>There is currently a seven-bed wing that has been closed due to low occupancy. The prospective provider plans to alter the structure of this vacant wing and external garden into secure areas, with the intention of adding to the number of dementia care beds.</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>	FA	<p>There are adequate numbers of bathroom and toilet facilities with varying levels of accessibility throughout the facility. This includes four shared toilets and showers in the rest home area, and four of the same in the hospital area. Seven rooms in this area have their own toilet and hand basin and there are two other separate toilets, one off the sunroom and the other along the corridor. The Rose wing, where dementia services are provided has two showers and toilets and one bathroom with a toilet. The Kowhai wing, where rest home or hospital care residents may be cared for have ensuite shower, toilet and hand basins.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident 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>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. All occupied resident's rooms are personalised with furnishings, photos and other personal items displayed. People choose their own rooms from those vacant at the time of entry, although families are encouraged to choose rooms closer to the nurses' stations if they, or their family member, has a high falls risk.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate,</p>	FA	<p>Communal areas are available for residents to sit and relax, watch television and/or engage in activities. There is a large dining and lounge area near the main rest home and hospital wings, which enable easy</p>

and accessible areas to meet their relaxation, activity, and dining needs.		access for residents, visitors and staff. A sunroom sits at the end of the Kowhai wing and a conference room at the end of the wing that is currently closed may be used for larger group activities. Two lounges and a separate dining area are in the dementia service. All residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.
<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>	FA	<p>Laundry is undertaken in an on-site laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Feedback regarding laundry processes in resident and next of kin survey results was overall positive.</p> <p>There is a small designated housekeeping team responsible for the cleaning throughout the facility. Both have received appropriate training from the chemical supply company and have completed the equivalent of New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry staff are also encouraged to attend any training available to caregiving staff.</p> <p>Housekeeping staff were familiar with the documented processes they need to follow and described precautions they need to take to protect residents, especially those in the dementia service. The effectiveness of laundry and housekeeping processes are regularly reviewed via the internal audit system and staff interviewed were able to describe how corrective action processes are managed when an aspect of their work has fallen short of expectations. Internal audit records confirmed these audit processes. The company the service provider contracts to supply chemicals undertakes audits on the laundry machines and chemical supplies, as well as providing staff training on chemical use and safety. Staff training records confirmed staff involvement in this training and the updates they undertake.</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>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility, including for the dementia care areas, in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. These meet the requirements of the Ministry of Civil Defence and Emergency and the local civil defence service. The current fire evacuation plan was approved by the New Zealand Fire Service on 30 June 2015. A trial evacuation is scheduled to take place six-monthly with a copy sent to the New Zealand Fire Service and this was most recently undertaken on 10 October 2020 and is due again now, and there are firm plans for this to occur. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures during interview.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas BBQ's were sighted and meet the requirements for the current number of residents. An emergency water tank is located on site and valve and water quality checks are components of the environment checklist. Emergency lighting is regularly tested. Emergency supplies of food to cover at least three days if needed was present on site.</p> <p>Call bells alert staff to residents requiring assistance. Monthly internal audits on call bell response timeframes are being completed and residents and families reported staff respond promptly to call bells. The manager was observed to intervene when a call bell had persisted longer than preferred.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at 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</p>	FA	<p>The facility is heated via a gas fired central heating system. Within the past year, heat pumps have been installed in two areas of the facility for cooling purposes as there had been reports of temperatures becoming</p>

comfortable temperature.		<p>excessively warm during summer months.</p> <p>All resident's rooms and communal areas have natural light and opening windows with security latches in place. Doors open onto garden and patio areas from the lounges in the rest home and hospital area and in the dementia wing. Residents and families confirmed the facilities are mostly maintained at a comfortable temperature throughout the year, although they noted that it is hot in summer.</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>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control policy with input from infection prevention and control specialists. An annual programme is in place and was sighted.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the business and facility manager, and tabled at the registered nurse and quality committee meeting, this committee includes the facility manager, IPC coordinator, the health and safety officer, and representatives from cleaning services.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</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 IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for one year. She has undertaken an on-line infection prevention and control course, as verified in training records sighted. Additional support and information are accessed from the infection control team at the TDHB, the community laboratory, the GP and public health unit, as required. Ministry of Health updates were used to guide protocol through lockdown during the Covid-19 pandemic. The IPC coordinator has access to residents' records and diagnostic</p>

		<p>results to ensure timely treatment and resolution of any infections.</p> <p>The registered nurse confirmed the availability of resources to support the programme and any outbreak of an infection. An outbreak box is available at all times.</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>There is a full suite of infection prevention and control policies and procedures developed at an organisational level that reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are current and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices and know where they are kept.</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>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by the IPC coordinator, registered nurses and facility manager. Content of the training is documented and evaluated to ensure it is relevant, current and understood. Records of attendances are maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. Examples of this occurring have been during the Covid-19 pandemic.</p> <p>Education with residents is generally on a one-to-one or case by case basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, encouraging residents to maintain good fluid intake and good personal hygiene, especially in relation to toileting.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, wound, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and influenza. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The nurse practitioner interviewed confirmed being informed in a timely manner of residents with suspected infections. The residents' infections as detailed in the sampled residents' files have been included in the infection surveillance data in the month the infection was diagnosed. Residents and family members confirmed they are informed of all suspected or actual infections and the plan of care.</p> <p>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 and benchmarked with other HLL facilities. There are documented definitions of infection for consistency.</p> <p>There have been no outbreaks in the last year.</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 care home manager informed the restraint coordinator provides oversight for enabler and restraint management in the facility. The restraint coordinator was interviewed. Staff are provided with copies of the organisation's policies, procedures and practice and those interviewed were aware of them and of the preference for the facility to be restraint free.</p> <p>On the day of audit, three residents were using restraints with one person using two types. All were one of three types of restraint approved for use in HLL facilities. Six residents were using enablers, which were reported as being the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints and there was evidence of their consent in their files.</p> <p>The care home manager informed that restraint is used as a last resort</p>

		<p>to promote independence and personal safety when all alternatives have been explored. A recent quality improvement project had been undertaken to reduce the number of restraints used, and this had reduced from ten in March 2020 to four in April 2021.</p> <p>Interviews and the documentation submitted confirmed that the prospective provider is versed with their responsibilities in respect of restraint minimisation and safe practice.</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>There is not currently a separate restraint approval group; however, the business and care manager and a registered nurse noted that restraint is a component of monthly registered nurse meetings. Registered nurse meeting minutes make comment on the people using a restraint, what type of restraint and who is due for review of their restraint. Use of a restraint or an enabler is part of the plan of care. Improvements made to the systems for managing restraint use and the documentation associated with this has improved since the audit in October 2020 and that corrective action is now closed.</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>The organisation includes a restraint assessment form within the restraint manual of related policies and procedures. Copies of an assessment form for restraint use was in the restraint register. The form for assessing the need for and the use of restraint is now comprehensively completed for all restraints in use. The previous corrective action is now closed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The care home manager and registered nurse informed the use of restraints is actively minimised and this was evidence by the reduction in restraint use over the past 12 months. Staff described how alternatives to restraints are considered and processes,, such as intentional rounding and use of sensor mats are trialled.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details.</p>

		<p>A restraint register is maintained, updated every month and reviewed at each registered nurse meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</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 understood the need for restraint use to be minimised and how to maintain safety when it is being used. They were fully conversant with restraint monitoring requirements.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Requirements around the use of the relevant restraints for each person using a restraint are in their care plan. Organisational policies and procedures describe the evaluation and review processes required by service providers for each person for whom a restraint is used. These are to be undertaken six-monthly. Improvements have been made to the evaluation process since the October 2020 audit and the previous corrective action is now closed.</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>	FA	<p>Registered nurses report the restraints being used at each monthly registered nurse meeting, and this was sighted in the meeting minutes reviewed.</p> <p>Restraint use reports are part of the monthly clinical indicators report that the service provider sends to the HLL Head Office. These reports are analysed for Dunblane as well as collectively with those from other HLL service providers and the extent and any trends are identified. No specific trends had been identified for Dunblane; however, an example of this process working is that there had been an overall increase in the use of restraint in HLL facilities early in 2020. A quality improvement initiative aimed at reducing restraint use in HLL facilities commenced in May 2020, and this has resulted in the reduction of restraint use at Dunblane Lifecare.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.