Heritage Lifecare Limited - Roseneath Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Roseneath 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: 2 June 2021 End date: 3 June 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 43

Executive summary of the audit

Introduction

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

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

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Roseneath Lifecare & Village provides rest home, hospital and dementia care for up to 49 residents. The service is operated by Heritage Lifecare Limited (HLL) and managed by a care home manager and an acting clinical services manager. Residents and families spoke positively about the care provided.

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

This audit resulted in seven areas identified as requiring improvement relating to document control management, internal audits, incident/accident process, the documented rationale for determining staffing levels and skill mix, service planning timeframes, evaluation of service delivery plans and the water temperature monitoring process.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

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

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.

The care home manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Heritage Lifecare Limited is the governing body and is responsible for the services provided at this facility. A business plan and quality and risk plans are documented and includes the goals/objectives, values and mission statement of the organisation.

Systems are in place for monitoring the services provided, including regular monthly reporting by the care home manager and the clinical services manager to the governing body.

The facility is managed by an experienced and suitably qualified care home manager who is a registered nurse. A quality and risk management system is in place which includes monitoring of complaints and incidents, health and safety, infection prevention and control, restraint minimisation, internal audit activity and surveys which are completed annually. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow-up where necessary. Meeting minutes, graphs of clinical indicators are available. Adverse events are documented and are seen as an opportunity for improvement. Corrective action plans are being developed by the care home manager and signed off when completed. Actual and potential risks are identified, mitigated and the hazard register is up to date.

Policies and procedures cover the necessary areas and are reviewed by the organisation’s support office management team.

The human resource management policy is based on good practice and guides the system for recruitment and appointment of staff. An orientation and staff education programme ensures staff are competent to undertake their role. A systematic approach to identify, plan and facilitate ongoing training supports safe service delivery. Staff annual appraisals are completed annually.

Staffing levels and skill mix reflect contractual requirements and the changing needs of residents. There is a roster of senior staff on call after hours.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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. Files reviewed demonstrated that the review and evaluation of care provided and needs of residents is an area needing improvement. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

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

Safe and appropriate environment

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

The facility has been purpose built. There are single rooms with one double room including some with ensuite bathrooms, all of adequate size to provide personal care to residents.

All building and plant complies with legislative requirements. The current building warrant of fitness is publically displayed. The electrical and calibration of all equipment has been completed annually.

Communal areas are spacious and maintained at a comfortable temperature. External areas with seating are available.

Implemented policies and procedures guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points in case of fire. Access to an emergency power source is available if needed. Residents report timely staff response to call bells.

Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and two restraints are in use at the time of the audit. Restraint is only used as a last resort when all other options have been explored. An assessment, approval and monitoring process with regular reviews occurs. Enabler use is voluntary for safety of residents in response to individual requests. Staff receive training at orientation and every two years thereafter. Training includes alternatives to restraint and dealing with difficult behaviours. Staff interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

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	44	0	1	4	1	0
Criteria	0	93	0	0	6	1	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	Roseneath Lifecare follows the organisational policies, procedures and processes of Heritage Lifecare to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training which last occurred in July 2020.
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. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. 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. Staff were observed to gain consent for day to day care.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Posters of the Code with information on the Advocacy Service were also displayed in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Part of the process when a complaint is registered, is that a letter acknowledging the complaint is sent out with contact information for advocacy service.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Conversations are documented in the progress notes in the electronic system, and by typing 'family' into search box will retrieve all entries of key conversations with family/whānau.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy in relation to care homes describes the complaints management process and response timeframes that are consistent with the Code of Rights. It describes responsibilities, provides an overview of processes including the management of a complaints register and the difference between high and low level complaints is outlined. The service has an open door policy and this was confirmed by the care home manager (CHM) interviewed. The regional clinical manager (RCM) interviewed discussed the complaints for the last year. There were 29 complaints received since January 2020 until the present time. Action plans show any required follow-up and improvements made where possible. All have been effectively closed out. The CHM and the RCM are responsible for the management of all complaints. There is one complaint which was recently received from the DHB and this is being managed by the RCM. The complaint reviewed evidenced that information is currently being prepared in response to the complaint in a timely manner. The head of clinical, at the organisations support office, is responsible for the closing off of complaints. All staff interviewed confirmed a sound knowledge of the complaint process and what actions are required.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the information provided on the posters displayed. The Code is displayed in the main entrance, outside the nurses' station and in the secure wing, together with information on advocacy services. The Code was available in both English and Te Reo Māori. A folder is

		available at reception for documenting minor concerns, and how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room. There is one double room that is available for married couples should it be required. Residents are encouraged to maintain their independence as per personal preferences and abilities. Some are encouraged to walk to the dining area, others supported to go out to community events, such as church, and others encouraged to attend activities or assist with their personal hygiene. Care plans included documentation related to the resident's abilities and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. Family/whānau informed they had not seen any examples of concern.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There 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. A volunteer has visited with a group of Māori residents and talked with them in Te Reo Māori. Due to lockdown this was restricted but is to be reinstated. Staff reported they greet these residents in Māori and acknowledge and respect their individual cultural needs.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic,	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Personal preferences expressed by residents, required. Interventions and special needs were included in the care plans reviewed with additional information on those identified within their social profiles and activities plans.

cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that there has been no evidence of any form of discrimination, harassment or exploitation and people said they believe they are safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the 'Heritage Way', which is the organisation's Code of Conduct. All employees are required to sign 'the Heritage Way' to confirm they have read and will honour it. 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the aged residential care palliative nurse specialist, and education of staff. Both the general practitioner (GP) and palliative nurse specialist interviewed confirmed the staff were responsive to medical requests and sort input in a timely manner. The clinical manager expressed pride in the overall commitment of staff in the care and support they provide, which was reiterated by residents and family members/whānau. Staff reported they receive management support for external education and access relevant professional networks to support contemporary good practice. Achievements of staff were acknowledged and certificates displayed in the corridor.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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. The registered nurses always contacted the family after regular or urgent medical reviews. This was reviewed and supported in the resident' records reviewed. Staff interviewed understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code. Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported by documentation in family/whānau contact record and evidenced in resident progress notes reviewed. Enduring power of attorneys are involved as indicated in each resident's file. For those in the dementia wing along with appropriate documentation of activation. Staff understood the principles of open disclosure, which is supported by organisational policies and procedures that meet the requirements of the Code.

		Staff know how to access interpreter services, although reported this had never been required due to all residents being English speaking. One resident who is aphasic has a booklet of pictures to help with communication and a vision impaired resident had signage on the door.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Roseneath Lifecare and Retirement Village business plan for 2021 was reviewed. There are documented organisation overarching goals and specific goals set for this service. Building relationships with other service providers in the region is the main objective for the Care Home Manager (CHM). The plan also outlines business requirements and measures for success such as financial, benchmarking, resident occupancy, quality management and continuous improvement, health and safety and meeting all compliance and building strong health and safety capability across Heritage Lifecare Limited (HLL) sites. Maintaining training and competencies for all staff annually is an ongoing achievement and maintaining excellence with quality of clinical care provision provided for residents. A sample of monthly reports were reviewed including financial performance, emerging risks and issues. The service is managed by a care home manager who holds relevant qualifications (is a registered nurse with a current annual practising certificate (APC) and has been in the role only for a short time since 12 April 2021. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CHM is well supported by the acting clinical service manager (CSM). The CHM confirms knowledge of the sector as previously worked and owned in her own facility, regulatory and reporting requirements and maintains currency through attending meetings and study days at the DHB and through the organisations management training days. The most recent conference for CHMs was in April 2021. The service holds contracts with the DHB including rest home, hospital and secure dementia care, palliative care, respite and long term support chronic health care for under 65 years. On the day of the audit 43 residents were receiving care including respite (Nil) 13 secure dementia, 11 hospital, one palliative care, 17 rest home and one LTSCHC.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe	FA	When the CHM is absent the acting CSM carries out all the required duties under delegated authority. The acting CSM is experienced in the aged care sector and has worked at this facility for approximately 10 years. The regional clinical manager is also available as necessary. During absences of key clinical staff, the clinical management is overseen by the CHM also an experienced registered nurse and/or senior registered nurses.

services to consumers.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate	The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by the staff interviewed. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint minimisation and safe practice. Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular reviews and analysis of quality indicators occurs and related information is reported and discussed at the management staff and quality meetings. Minutes were reviewed. Over a few months there was a gap in service delivery when there was no CHM and there was some inconsistency of maintaining the required information other than for reporting purposes for example few internal audits were completed as per the schedule reviewed, policies and procedures are outdated and incident reporting statistics (refer to 1.2.4.3) was not being reported back to management and to the meetings and corrective actions were not being developed and implemented for continuous improvement. Meetings continued to be held on a monthly basis with the RCM covering in the absence of the CHM. The resident annual survey was completed last in September 2019. The survey is sent out from support office not by the service providers. Residents meetings were being held regularly monthly. These areas were identified as areas for improvement to adequately meet this standard.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	Staff are aware of the required process for reporting incidents and accidents including near miss events. All staff are provided with education on their responsibilities for reporting and managing accidents and incidents during their orientation and as a component of the ongoing education programme sighted. Applicable events are being reported in a timely manner and disclosed to the resident and/or designated next of kin. This was verified by residents and a family interviewed. There are several areas where staff can document these communications. A review of reported events including falls, a medication error demonstrated that incident reports are completed but not always responded to. Staff communicated incidents and events to oncoming staff at handover between shifts. Some incidents were followed through and discussed at the staff meetings and this included discussion on prevention strategies. The incident register was sighted but had not been maintained since the beginning of 2021 to April 2021. The register had 140 incidents that had not been closed out effectively. This was an area of improvement identified. The CHM was fully informed about the essential reporting requirements for serious and/or notifiable events to statutory and regulatory agencies. There have been three section 31 notices in the last year reported to the appropriate agencies.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Randomly selected staff personal records were reviewed. Positon descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being followed and records are systematically maintained. Staff orientation includes all necessary components relevant to the role. Staff interviewed 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 show documentation of completed orientation and a performance appraisal annually. All staff appraisals were current and up to date. The HLL staff checklists in the front of the records reviewed is easy to follow through to ensure all requirements are addressed when employing new staff and maintaining the records accurately. Four of six registered nurses are interRAI competent and competency certificates were reviewed. Continuing education is planned annually. Mandatory training requirements are defined and scheduled to occur over the course of the year. Care staff have either completed or commenced a New Zealand Qualifications Authority (NZQA) education programme to meet the needs of the provider's agreement with the DHB. There are 28 healthcare assistants (HCAs). Education records reviewed demonstrated completion of the required training with ten already trained in level one, three are level two, seven are level three and five are level four (25) in total. One HCA is currently training as a registered nurse and is in the third year of training. One HCA is enrolled in the diversional therapy level 4 training and one HCA is yet to enrol in the programme. Education is now recorded on a spread sheet and not kept in the staff individual records reviewed.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate	There is no documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The CHM stated that they adjust the staffing level as required to meet the changing needs of residents when possible. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Residents and families interviewed were pleased with the care received. Care staff reported adequate staff were available and that they were able to complete the work allocated to them however the four week rosters did not reflect this occurred. The service does not have adequate care staff to cover in the late afternoon shift and the night shift should assistance be required for a resident in either the special dementia service or the rest home hospital should an incident occur. Management stated that the registered nurse on call would come into the facility if required should an incident occur. This was identified as an area of improvement to meet this standard.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. This includes interRAI assessment information entered into the Momentum electronic database. Roseneath Lifecare uses an electronic system for resident files. GP and allied health service provider notes, discharge summaries, and referrals are scanned into the system. Each staff member has a unique password to maintain privacy and only have access to information pertinent to their scope of practice. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site for a year before being transferred to a secure storage facility for the appropriate length of time. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service 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 families are encouraged to visit the facility prior to admission and are provided with an enquiry pack that contains written information about the service and the admission process. The organisation seeks updated information from relevant sources such as the GP for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort and transport made available as appropriate. The service uses the DHBs 'yellow envelope' system to facilitate transfer of residents to and from acute care services. It was reported that there is open communication between all services, the resident and the family/whanau with one person relaying their experience. At the time of transition between services, appropriate information is reportedly provided by a printout from the electronic system for the ongoing management of the resident and will include medication records. All referrals are documented in the progress notes.
Standard 1.3.12: Medicine	FA	The medication management policy and procedures are current and identify all aspects of medicine

Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Medicine management competencies were sighted for registered nurses, and second-checker. All staff who administer medicines are competent to perform the function they manage, and this was confirmed in records sighted. Specimen signatures were available. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. A registered nurse checks the medications against the prescription and enters this into the person's electronic record. All medications sighted were within current use by dates. Clinical pharmacist advice is provided on request, otherwise they visit to undertake six-monthly checks of controlled medicines. 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 stock checks as well as six-monthly pharmacy stocktakes. The records of temperatures for the medicine fridge, medication room and medication trolley are consistently documented in the electronic system and were within the recommended range. Good prescribing practices were evident within the electronic system with dates recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) prescribing met. All medicine records that were checked at audit had been reviewed by the GP within the past three months. With the electronic medicine management system in place, standing orders nor faxed medicine records are no longer needed. There were no resident's self-administering medications at the time of audit. An implemented process for comprehensive analysis of any medication errors via the incident/adverse event reporting process is in place. There has been a high number of medication errors which is a result of not entering effectiveness of pro re nata medications into the system. This is currently being addressed and is referenced in 1.3.8.2 as part of the corrective action around evaluation.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a	FA	The food service is provided on site by a two cooks and kitchen team and is in line with recognised nutritional guidelines for older people. A four-week rotating menu follows summer and winter patterns and has just been reviewed by a qualified dietitian as confirmed by head office in January 2021. 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 the local district council and has an expiry date of 2 March 2020. Food temperatures,

component of service delivery.		including for high risk items, are monitored appropriately and recorded as part of the plan. Likewise, equipment checks such as fridge and freezer temperatures and cleaning schedules are checked daily. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. Certificates were displayed outside the kitchen. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The registered nurse supplies the kitchen with a copy of these records, including when there are any updates or changes required. The personal food preferences, any special diets and modified food texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, such as lipped plates and lidded beakers are available. Evidence of resident satisfaction with meals was verified by resident and family interviews, and resident meeting minutes. Residents expressed that if they didn't like the option that an alternative would be offered, and that food was hot when served. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Residents in the dementia unit have access to snacks at any time.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently 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 was given when a palliative resident was declined as the only available bed was too far from the nurses' station to provide safe monitoring. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information 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 care plans reviewed had an integrated range of resident-related information. Three resident files reviewed had 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.
Standard 1.3.5: Planning	FA	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

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.		reflected in care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff at handover. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations, and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP and an aged residential care palliative nurse specialist were interviewed and both verified that medical input is sought in a timely manner, that medical orders are followed, care is appropriate, and they had no concerns regarding the quality of care. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level/s of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by a trained diversional therapist (DT) holding the national Certificate in Diversional Therapy for the hospital and rest home. In the dementia unit there is an activities coordinator with mental health training. The DT was on annual leave at the time of audit but had been replaced by a relieving DT who has relieved at the facility before, therefore maintaining the programme and providing stability for the residents. 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 informally by resident engagement and feedback but there was no evaluation or documentation of the residents' progress towards goals documented in the resident files, (see 1.3.8). Attendance records were entered in to the electronic system. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings. Residents interviewed confirmed they find the programme varied and stimulating. In the secure dementia unit activities 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. Each resident has a 24 hour strategy to minimise challenging behaviour. Family members interviewed expressed that the

		programme had a high level of participation which was confirmed by attendance records.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA High	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN who is responsible for assessing the situation and initiating appropriate follow up. Formal care plan evaluations and the six-monthly interRAI reassessment are not consistently occurring as evidenced by the number of overdue interRAI assessments. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were unable to be sighted consistently. One wound care plan evidenced regular dressing changes and progress towards healing, out of four wound care plans reviewed. Neurological recordings post fall were inconsistently documented as was progress on activities and evaluation of the programme. Pro re nata medication was not consistently having effectiveness documented. Residents' monthly observations were again not consistently taken and follow up of weight loss and observations outside prescribed parameters were not followed up. Residents and families/whānau interviewed provided examples of discussions around evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to speech language therapist, Mental Health, Addictions and Intellectual Service and an email to a GP regarding a change of condition of a resident and requesting a visit. 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.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous	FA	Documented processes for the management of waste and hazardous substances were in place and the policy has been reviewed April 2021 following the organisation's documentation review. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal. The doors to the areas storing chemicals were secured and containers labelled. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide staff training as was verified in the training records. Material data sheets were available where chemicals are stored and staff interviewed knew what to do should any

substances, generated during service delivery.		chemical spill occur. Any related incidents are reported in a timely manner. There is provision and availability of personal protective clothing and equipment and staff were observed using this during the audit including hats, aprons and gloves and masks.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate	A current building warrant of fitness expires 28 June 2021. This was displayed publically at reception. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. The last environmental scan checklist was completed 22 January 2021. There is a proactive and reactive maintenance programme. The testing and tagging of electrical equipment and calibration of the bio medical equipment is current and was checked last 27 May 2021 and confirmed in documentation reviewed. The maintenance person was not available at the time of the audit. The temperature monitoring has occurred but documentation reviewed demonstrated variances with the water temperatures were not being reported to management. This was an area identified for improvement. A random audit was undertaken at the time of audit indicating the variable temperatures and a plumber was called immediately to review the situation. Some temperatures were very low and some were over the required level of acceptability for rest home, dementia and hospital resident safety. External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and they are happy with the environment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There is a mix of toilet, showers and bathing facilities. This includes rooms with ensuites, shared bathrooms and communal bathrooms with showers and toilets being in close proximity to residents rooms. There are adequate numbers of accessible bathrooms and toilets throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. There is a separate toilet for staff and visitors to the facility.

Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their rooms safely. All bedrooms provide single accommodation. There is only one shared room and this has one resident allocated to this room. Rooms are personalised with photographs, paintings and other personal items displayed. There is room to store mobility aids walking frames and wheelchairs. And for staff to use hoists when needed. Staff reported the adequacy of the bedrooms. There are only two rooms that are small in size and are used mostly for respite care rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is undertaken onsite in a dedicated laundry. Resident's personal items are laundered on site or by family if requested. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The staff interviewed demonstrated a sound knowledge of the laundry processes, dirty and clean flow and handling of soiled linen. There is a small designated cleaning team and two cleaners are rostered on each day. The cleaners interviewed had received appropriate training. Chemicals are stored in a lockable cupboard and were in labelled containers. Cleaning and laundry processes are monitored through the internal audit programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and procedures and any guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides the facility in their preparation for any disasters and describes the procedures to be followed in the event of a fire or any other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service Hutt Wairarapa on the 23 October 2012. A trial fire evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent fire drill was held on the 24 March 2021. Fire warden courses are also provided and are regularly planned in the education programme reviewed. The orientation programme for all staff includes fire and security training. Staff interviewed confirmed their awareness of the emergency

		procedures for this facility. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas BBQ was sighted and meet the requirements for 49 maximum residents. Water storage tanks are located around the facility. There is emergency lighting which is regularly tested. There is no generator in the event of a power outage however a plan is in place for hiring of a generator locally if and when needed. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff responded in a timely manner to call bells. Appropriate security arrangements are in place. External security lighting is in place. Doors and windows are checked and closed at a predetermined time.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas have opening external windows. Sky lights are also situated throughout the facility for additional lighting. Heat pumps were available in hallways, in the large dining room and other service areas. Oil filled heaters are visible in the small lounge areas. One heat pump was currently being repaired in the main lounge but may need to be replaced and this was to be decided on the day of audit. Areas were warm including the bathrooms and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	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 manual, with input from the organisation's national office. The infection control programme and manual are reviewed annually. A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. The Infection control matters, including surveillance results, are reported monthly to the clinical manager, facility manager and tabled at the quality/risk committee meeting. 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. QR code and sign in sheets are available at reception for contact tracing purposes.

Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and was appointed to the role eighteen months ago. Appropriate training has been provided through attendance at DHB study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. The organisation is undergoing a major policy review at national level and infection control policies were released in March 2021 but were not sighted in the facility (see 1.2.3.4). Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. Additional training was provided on hand hygiene and personal protective equipment during the nationwide lockdown. The organisation kept the facility updated on changes of levels and requirements during this time. Education with residents is generally on a one-to-one basis and has included reminders about

		handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, and upper and lower respiratory tract. 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. Infection data is entered into a register on the electronic system by the RN reporting the infection. This is printed off each month and collated, analysed, trends and causative factors observed and required actions implanted. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, quality committee and reported to the regional quality manager. A review of a recent gastrointestinal outbreak showed the outbreak was handled appropriately, procedures followed and documented. Learnings have been incorporated into the plan for reference during future outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The acting clinical services manager/restraint coordinator who has been in this role for five years, provides support and oversight for enabler and restraint management in the facility and demonstrated a good understanding of the organisation's policies, procedures, practice and the role and responsibilities. On the day of audit two residents were using restraints and no residents were using enablers which were the least restrictive and used voluntarily at a resident's request. A similar process is followed for the use of enablers as is used for restraints. This provides for a robust process which ensures the on-going safety and wellbeing of the resident. Restraint is used as a last resort. This was evident on review of the restraint approval group minutes and records of those residents who have approved restraints and from interview with staff.
Standard 2.2.1: Restraint approval and processes Services maintain a process	FA	The restraint approval group made up of the general practitioner and the acting clinical services manager are responsible for the approval of the use of restraints and the restraint processes as defined in policy. This is clearly defined in policy. It was evident from the approval group meeting minutes, review of the residents' records and interview with the coordinator that there are clear lines of accountability, that all

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.		restraints have been approved and the overall use of restraints is being monitored and analysed. Evidence of family involvement in the decision making, as is required by the organisation's policies and procedures was on record in each case, the use of the restraint is included in the interRAI assessment and the care planning process and documented in the plan of care.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator's involvement and input from the resident's family. The restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner has input into the final decision on the safety of the use of the restraint. The assessment process identified in the final decision on the safety of the use of the restraint. The assessment process identified the underlying aetiology, history of restraint use, cultural needs if any are taken into consideration, alternatives and associated risks if known. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraint is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as the use of sensor mats and low beds are explored before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs and this is documented on the electronic system in place and used by staff. The checks ensure the resident remains safe. Advocacy and privacy is respected and maintained at all times. This is included in the resident's care plan and monitoring forms reviewed recorded that this had occurred as required. A restraint register is maintained and updated every month after being reviewed at the group meeting. The two residents using a restraint were entered into the register. The type of restraint used is clearly documented. Staff have received training in the organisation's policy and procedures and in related topics. Staff interviewed understood that the use of restraints is to be minimised and how to maintain safe use was confirmed.

Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of resident's records evidenced the individual use of restraints is reviewed and evaluated during the care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. The last restraint meeting was held on the 21 May 2021. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation includes all requirements of the Standard including future options to eliminate use, the impact and outcomes achieved, if the policy and procedures was followed and documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint committee undertakes six monthly review of all restraint use which includes all the requirements of the Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of the restraint and feedback from the GP, staff and families. A six monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the restraint coordinator confirmed that the use of restraint has been reduced over the last year.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Moderate	The organisation (HLL) develops and implements policies, procedures and guidelines that are aligned with current good practice and service delivery and meet the legislative requirements as defined on each policy. The policies and procedures are sent out by the governance compliance and risk team, to services for consultation/comments at the time of the review. This was discussed with the CHM and the regional quality manager. When feedback has occurred the policy is changed accordingly and reimplementation of the policy occurs. At the time of audit the policies and procedures reviewed had not all been reviewed in the timeframes required (refer to 1.2.3.3) and/or in line with the organisations document control system. Staff interviewed stated they do not get to see policies out for review.	The organisation has a document control system to manage policies and procedures. This is the responsibility of the support office quality management team. The current system is not functioning adequately to ensure the CHM has updated policies and procedures that have been approved, reviewed, dated and are up-to-date. Policies and procedures have not been reviewed and brought to the attention of staff. Current policies are out of date - some dated 2014 and	To ensure there is a document control system that is effective to manage the policies and procedures. The system should ensure documents are approved, up to date and available to service providers and managed to prelude the use of obsolete documents. 90 days

			2015.	
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	An internal audit schedule was reviewed. The yearly schedule is documented and reflects what audits are to be completed each month. Random audits were selected. The information available was inconsistently recorded. When an audit was completed there was minimal information to verify whether a corrective action was required or follow-up had actually occurred. This was discussed with the CHM and the regional quality manager present at the audit. Quality improvement data (refer to 1.2.3.7) inclusive of the internal audits and clinical indicators, complaints, adverse events, infection control issues and restraint minimisation outcomes was not always available, communicated to staff where appropriate.	Quality data has been inconsistently gathered since the previous audit and when information is analysed. Evaluated or in particular when a corrective action is required for continuous improvement, this is not always actioned, followed through, signed or dated and identified risk is not acknowledged. Minimal strategies are in place to obtain feedback from staff, families and/or residents for continuous quality improvement purposes. The last annual survey was dated September 2019.	To ensure the process is followed for measuring achievements across the services provided. Quality improvement data is collected is to be consistently analysed and evaluated for achievement against the quality and risk management plan implemented. 90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to	PA Moderate	The incident register was available and was reviewed. Staff report all incidents in a timely manner. The registered nurses scan the forms into the electronic system and monthly the clinical services manager reports the incidents to the regional quality manager. These are reported to support office and are benchmarked across the organisation e.g. falls, pressure injuries, skin tears and medication errors. The clinical services manager closes off incidents as soon as possible.	In the last six months there have been 172 incidents reported by staff and 31 incidents have been actioned/addressed and/or closed out effectively in the incident register reviewed. 140 incidents were reported prior to April 2021.	All incidents are to be followed through in order to identify and manage any risks and/or opportunities to improve service delivery. 90 days

improve service delivery, and to identify and manage risk.				
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	The policy in place was reviewed. Families and residents stated they were pleased with the care provided. The policy sighted does not clearly document a process which determines service provider levels and skill mixes in order to provide safe service delivery. One month weekly rosters were reviewed. The regional quality manager stated the process as being based on resident numbers for clinical staff to be assigned to areas in the facility. On night duty in the secure dementia service there is one caregiver on night duty and one caregiver and one registered nurse on night duty in the rest home/hospital.	There is no documented and implemented process which determines service provider level and skill mixes in order to provide safe service delivery. When the rosters were reviewed there are two times in the 24 hour period when there is only one health care assistant in the evening both in the rest home/hospital and secure dementia care service. Due to the layout and design of the services this is not adequately covered to meet the needs of the residents. In addition to these findings, staff with first aid certificates are not identified on the rosters reviewed.	To ensure there is an appropriate policy with a rationale for determining staffing levels and skill mixes in order to provide safe service delivery. There has to be adequate staff on duty to cover the respective services as required on all shifts and a staff member with appropriate first aid skills is to be rostered on all shifts in all service areas. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision,	PA Moderate	Assessments are being undertaken on admission with two of seven files showing completed documentation. In the five remaining files there was incomplete information documented, with gaps in the interim care plan. InterRAI assessments and care plan review are not happening within the required time frames and are overdue in eight residents (three of whom are new residents) dating back to March	Full and complete assessments are not being completed as required within 24 hours of admission for all residents to inform the long term care plan. Eight	All interRAI and care plan assessments/reassessments are current and completed within the required time frames.

evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		2021.	interRAI reassessments and care plan evaluations are outstanding dating to March 2021.	90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA High	On the day of audit five of seven files reviewed had aspects of documentation missing. The missing documentation is not consistent between files – one file has short term care plan evaluations but no evidence of wound care management, while another file has no short term care plan at all. Short term care plans are inconsistently evaluated past the date of implementation, and progress is not adequately documented. Pro re nata medications are not evaluated effectively resulting in a high number of medication errors. Neurological observations are not completed in line with best practice recommendations. Wound care plans are started but not consistently evaluated and signed off when healed. Activities staff are not documenting in residents' files goals met and progress made towards desired outcomes. Residents' weights are monitored spasmodically but there was no follow up for a resident who had significant weight loss or for a resident's blood pressure outside of prescribed parameters. These shortfalls in documentation compromise the communication between shifts, reducing continuity of care between shifts, leading to a compromised standard of care for residents. Management are aware that documentation is not being completed as required and have a plan in place to provide more resources to solve this issue.	Evaluations across many areas of service intervention such as interim care plans, short term care plans, monitoring of weights, monthly recordings, neurological recordings post falls, wound evaluations and effectiveness of pro ne rata medications are not being consistently evaluated and progress achieved towards meeting goals of care is not being adequately documented.	Evaluations of monitoring systems, effectiveness of interventions and progress towards meeting desired outcomes need to occur and be adequately documented to meet contractual agreements. 30 days
Criterion 1.4.2.4 The physical	PA Moderate	The hot water temperature monitoring was occurring as demonstrated in the documentation reviewed. However the temperatures recorded varied significantly in different areas	The maintenance manager is responsible for water temperature	To ensure the water temperatures monitoring occurs monthly and that any

environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.		of the facility and no action was being taken. A random audit was arranged during the audit and this indicated variances of low and hot water temperatures. This was actioned by the CHM and a plumber was contacted and was visiting the home the same day as arranged.	monitoring on a monthly basis. Records evidence that these are completed but water temperature variances were not being reported to the CHM and action taken as a result.	variances are reported to management in a timely manner and that action is taken when necessary to ensure safety for residents. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.