Heritage Lifecare Limited - Clutha Views

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Clutha Views 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: 27 October 2021 End date: 28 October 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: 63

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

Clutha Views Lifecare provides rest home, hospital and dementia rest home care for up to sixty-seven residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager. There has been a change of facility manager since the last audit. Residents and families provided feedback about the care that was consistently positive.

This unannounced surveillance 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 files, observations and interviews with residents, family members, management, staff and a general practitioner.

No corrective action follow-up was required from the last certification audit. Seven areas requiring improvement were identified during this surveillance audit. These related to corrective action follow-up, risk management, staffing levels, interRAI assessments and reassessments, care plan development, evaluation and review and medication management.

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.

Open communication processes between staff, residents and families are occurring and reported to be effective. The managers and staff have access to interpreting services if required.

Information about the complaint process is readily available. A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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

Organisational and local business plans are in place and include the scope, direction, goals, values and mission statement of both the organisation and the facility. These sit alongside a comprehensive quality and risk management plan. Monitoring of the services provided to the governing body is regular and effective. 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 are involved and feedback is sought from residents and families. Adverse events are documented with actions to mitigate risks of recurrence implemented. Health and safety risks are identified and mitigated, and a hazard register is being monitored. Policies and procedures support service delivery and are reviewed regularly.

Processes around the appointment, orientation and management of staff are based on current good practice. Internal and external training opportunities which support safe service delivery, are available to staff. Regular individual performance reviews are occurring.

A system for managing safe staffing ratios and skill mix is in place and used as a basis for staff rosters.

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.

Registered nurses are responsible for each stage of the service provision. A registered nurse assesses, plans, and reviews residents' needs, outcomes and goals with input from the resident and/or family. The general practitioner reviews the residents three monthly or earlier if required.

The service provides a planned activity programme which offers a variety of individual and group activities and maintains links with the community. There is a facility van available for outings as COVID-19 restrictions allows.

There is an electronic medication management system in place and the staff who administer the medications are competent in medication management. All medications are reviewed by the general practitioner every three months, or as necessary according to policy.

The onsite kitchen meets the nutritional needs of the residents and there is food available 24 hours of the day. Residents with specific dietary requirements and likes and dislikes are well catered for. Residents and family members expressed satisfaction with the meals and the choice available. The service has a four-week rotating menu which has been approved by a registered dietitian.

Safe and appropriate environment

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

There is a current building warrant of fitness on public display.

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. Three enablers and one restraint were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff 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 control programme is led by the clinical services manager (CSM). The infection control policy identifies current best practice for infection control management. Infection data is collated monthly by the CSM and presented at the quality and risk management meetings. The service engages in benchmarking nationally with other facilities.

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	10	0	1	5	0	0
Criteria	0	34	0	2	5	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The compliments and complaints 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 informed they would speak to the manager if they were dissatisfied with anything. There is additional information on how to make a complaint in the front foyer. A complaints register was reviewed and showed that eight complaints have been received since the start of 2021 and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans and the complaint register showed any improvements have been made where possible. The facility manager is responsible for complaints management and follow up with assistance available from the support office if needed. Verbalised concerns are recorded and actioned within the complaint process. All staff interviewed noted they would escalate any concerns to a registered nurse, or the manager, and confirmed a sound understanding of the complaint process. There have been no complaints received from external sources since the previous audit.
Standard 1.1.9: Communication	FA	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 in residents' records reviewed and in the incident reporting system records. Staff

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter service policies and procedures are accessible to staff. The manager is familiar with the policy and described how to access local and internet based interpreter services. Staff reported they had never needed to use interpreters, although noted that at times they had to work out strategies as a team and share experiences to ascertain the best methods of communication with some residents, especially those with cognitive decline or a speech impairment.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	A Heritage Lifecare Limited business plan for Clutha Views is in place and covers the scope, vision and values of the organisation, describes 'the Heritage Way' and includes operational plans for the organisation. The values of the organisation have recently been reviewed. There are also goals and objectives specific to Clutha Views Lifecare. Monthly monitoring reports on key clinical indicators are provided to the support office. Copies of these were reviewed and included aspects of quality improvement and the identification and reporting of ongoing and any emerging risks. As noted in the corrective action for criterion 1.2.3.8, the associated corrective actions lacked transparency. A regional manager maintains vigilance with ongoing telephone and personal meetings with the facility manager. Heritage Lifecare Limited has recently employed a new clinical quality manager who, alongside the regional manager, is aware of the current staffing and clinical issues of concern at Clutha Views Lifecare and are providing support and advice as applicable. Clutha Views Lifecare is managed by a facility manager who holds relevant business management qualifications and has been in the role for approximately five months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. With extensive overseas management experience in the aged care sector, the facility manager is progressing their knowledge of the New Zealand regulatory and reporting requirements. Managers from the Heritage Lifecare Limited (HLL) support office, the local District Health Board portfolio manager and managers from two other HLL facilities provide additional support. On the day of audit, the usual clinical services manager was on leave and a temporary clinical services manager on a three week assignment was present. A manager from another HLL facility was also present and assisted with the audit on day two. In addition to rest home, hospital and dementia rest home contracts under the Aged Related Residential Care agreement (ARRC), the service also holds contracts with the Southern District Health Board for respite, palliative care and long term chronic health conditions. Thirty three residents were receiving services under the ARRC agreement for hospital level care, sixteen for rest home care and fourteen for dementia care at the time of audit. One of the hospital level care residents is on a long term chronic conditions contract and one dementia care resident passed away on the morning of the first day of the audit.

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 Low	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of complaints, incidents and accidents, internal and external audit activities, a regular resident and family satisfaction survey, monitoring of a range of clinical indicators including pressure injuries, falls, infections and restraint use. Meeting minutes reviewed confirmed reports that there had been a period of some months when quality and risk management system reviews were not occurring. However, the current facility manager has now reinstituted these reviews and meeting minutes over the past three months showed regular review and analysis of quality indicators. Related information is reported and discussed at monthly quality and risk team meetings, staff meetings and resident meetings with evidence of these in meeting minutes reviewed. Staff reported their involvement in quality and risk management activities through attendance at education, reading meeting minutes and attending meetings when they can. Examples of corrective actions being developed and implemented to address shortfalls were viewed; however, a corrective action has been raised from this audit as further development is required in this area. Resident/family satisfaction surveys are completed annually. The most recent survey was in April/May 2021 and showed overall satisfaction, with food, laundry and communication being identified as areas for further improvement. Plans and actions underway to address these issues were discussed but have yet to be formalised as corrective actions/quality improvements. Policies 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. Organisational documents are based on best practice and were being reviewed to reflect the new standard. The document control system managed via the support office ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The facility manager described the responsibilities of the support office in monitoring organisational risks. A corrective action has been raised as there is not currently a facility wide risk management plan/matrix. Nor are associated processes in place for the identification, monitoring, review and reporting of risks and development of mitigation strategies, especially related to service provision at Clutha Views Lifecare. Health and safety reviews are ongoing as are those of the facility based hazard register. Two staff have been trained in the Health and Safety at Work Act (2015) and requirements have been implemented.
Standard 1.2.4: Adverse Event Reporting All adverse,	FA	Staff document adverse and near miss events into an electronic incident reporting database as well as within residents' progress notes. The database forms a register which showed that individual incidents/accidents are being regularly recorded, followed up, reviewed, and actions taken when individual prevention strategies are identified. Adverse event data is collated, analysed and reported to the support office for comparison with other facilities within the organisation. As identified in the corrective action under Criterion 1.2.3.8, the reporting of corrective

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.		actions/quality improvements related to facility level trends from incidents is difficult to follow. Some action plans and follow-up for both individual and trend related adverse events are reported within quality and risk meeting minutes, some in registered nurse meeting minutes and some such as falls, pressure injuries and wounds are within the monthly clinical indicator reports from the clinical service manager to the support office. Others were verbally reported by the facility manager. On careful investigation, there was evidence that follow-up for identified trends is occurring but the process requires improvement. The facility manager described essential notification reporting requirements for a range of issues including coroner's reports, liaison with the local public during a recent infection outbreak and section 31 reports to the Ministry of Health. Section 31 reports were mostly related to resident/staff and resident/resident verbal and physical aggression, primarily within the dementia service. While there is good reporting of these, observation about the number of them was discussed with the facility manager. As per the corrective action in 1.2.3.8, actions are being taken including reassessment of some residents and behaviour management training for staff. It was not possible to ascertain whether staffing issues as noted in 1.2.8 are contributing to this issue. There have been no police investigations, nor complaints/concerns via the Health and Disability Commissioner. Issues raised with the Health Integrity Line in November 2020 were followed up during the audit. Staff did not describe bullying as a concern and nor did any residents. However, staff did speak of considerable stress related to heavy workloads, low staffing levels and lack of clinical leadership and care plans. The facility manager described actions underway and additional plans in place to address the issues raised (refer Standard 1.2.8.). Training is progressively occurring according to the planned schedule and appropriate supports are in place for the registered nurse team, which include additional access to training as required and the employment of additional registered nurses.
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	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process is comprehensive and is tailored to individual needs and previous experience in the field. Staff records reviewed showed documentation of completed orientation and a conversation with the facility manager regarding training and personal development requirements after a three-month period. A 2021 continuing education plan was reviewed and includes mandatory training requirements and competency updates. Staff records demonstrated that staff are meeting the training requirements and that care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the District Health Board. Similarly, staff working in the dementia care area have either completed or are enrolled in the required education. The facility manager and temporary clinical services

		manager noted that the enrolled nurses and the two new registered nurses are on a priority list for training on undertaking interRAI assessments. When completed they will supplement the two other registered nurses who are maintaining these competencies. The clinical services manager responsible for assessing other staff for their competency with medication management does not have a current medication competency (refer corrective action 1.3.12.3). Records reviewed also confirmed staff annual performance appraisals are up to date.
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 an organisational Heritage Lifecare Limited documented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). This is supplemented by a breakdown of the specific process for the Clutha Views Lifecare facility. The facility manager is on call 24/7, with the clinical services manager responding to clinical related issues. At least one staff member on duty has a current first aid certificate and there is 24/7 registered nurse coverage in the hospital. Residents and family interviewed were positive about the care provided and did not express concerns about staffing levels other than to mention the length of time it takes for call bells to be responded to. However, concerns were raised during staff interviews, and these were validated in documentation of six weeks of rosters that were sighted, management interviews and in residents' documentation, that lacked the basics of assessment, care planning and reviews. Although the facility manager described a recruitment process that has been underway to increase staff numbers, it is taking time for this to be effective and ensure all shifts are adequately covered by suitably skilled and/or experienced service providers. Recent actions taken of allocating enrolled nurses as team leaders in all three key service areas, the employment of two new registered nurses who have just completed two weeks of orientation and the recruitment of new caregivers that is underway were examples of ways in which the organisation is addressing the identified risks. These actions enabled the risk rating of the finding in this standard to be reduced from high to moderate.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	PA Moderate	The medication management policy is current and identifies all aspects of medicine 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. All staff who administer medicines have been assessed as being competent to perform the function they manage, except for the CSM who oversees medication competency assessments. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy over a three-day period. The RN checks medications against the prescription, but not all RNs are signing the medications in on the electronic system. All medications sighted were within current use by dates. Clinical pharmacist input is provided as

guidelines.		required. 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. There were discrepancies identified with totals carried forward and a review was completed by an external manager. The records were correct when checked between the physical stock and the amount recorded in the controlled drug book once the incorrect calculations entries were carried forward accurately. A plan is in place to provide education to those staff who are entering transactions into the register. Controlled drugs are signed in by the RNs and a pharmacy check is carried out every six months. This was evidenced in the controlled drugs register. The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room temperature is also monitored. Good prescribing practices were noted, included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was not consistently recorded on the medicine chart. Standing orders are not used. There were no verbal orders. Vaccines were not stored on site. COVID-19 vaccinations are a continuing process. There was one resident self-administering medication at the time of audit, and this was being overseen and signed off by the hospice. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site with a cook 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. 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 district council. At the time of the audit the kitchen was observed to be clean, and the cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet residents' nutritional needs is available. There are snacks available 24 hours a day with sandwiches, yoghurt and cakes in the dementia facility. Evidence of residents' satisfaction with meals was verified by resident and families/whānau interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had

		this provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	When a residents' condition alters, the RN initiates a review and if required a GP consultation. Electronic short term care plans are utilised for changes in health and various monitoring charts. Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs. However, there were no care plans with identified and measurable goals available for four out of six files reviewed on the day of the audit. Care staff confirmed that care plans were not always up to date and available for each resident. These were previously used, but the nurses noted that they were now too busy to complete them. Progress notes are informative and clearly documented. The attention to meeting a diverse range of resident needs was evident in areas of service provision and well documented in progress notes. The GP reported that the service is providing a good standard of care and confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the GP should a resident's condition change. A range of equipment and resources are available and suited to the level/s of care the facility provides.
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 full-time diversional therapist (DT) who supports the residents in the dementia unit Monday to Friday 8.30am until 5.00pm. The DT is supported by two activities co-ordinators who cover the rest home and hospital Monday to Friday 9am – 3.45pm. Activities over the weekend are facilitated by care staff in the rest home, hospital, and dementia facility, with a weekend activity plan available. There is a 24-hour plan available for staff to access specific to residents needs in the dementia facility. The DT expressed at times due to staff constraints they were not always fully utilised in that role. (Refer criterion 1.2.8.1). An assessment is completed on admission, and a history undertaken to ascertain the resident's needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. Activities reflected the resident's goals, ordinary patterns of life and included normal community activities, regular church services, Housie, and knitting. There are a range of visitors to the facility as COVID-19 allows. There are individual and group activities offered and a weekly van outing. Due to COVID-19 van outings have only just begun again and visiting entertainment is restricted. Two staff members go on the outings and must be double vaccinated. There are two lounge areas available in the rest home and hospital and one available in the dementia unit as well as the individual's bedrooms where they can watch their own television or listen to the radio. The activities calendar is on display and each resident is given a copy of the weekly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular basis.

		Residents and families can evaluate the programme through day-to-day discussions with the activities co-ordinator and by completing the resident satisfaction survey. Residents interviewed confirmed the programme was interesting and varied.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate	Resident care is evaluated on each shift and documented in the progress notes. If any change is noted this is reported to the RN. Where progress is different from that expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being constantly reviewed, and progress evaluated were noted for wounds in one of the files reviewed. When necessary and for ongoing problems, long term care plans are added. Not all residents had a long-term care plan in place; therefore, no evaluation of resident's goals was possible. Residents' families/whānau interviewed expressed satisfaction with the level of care provided. Formal care plan evaluations occur every six months in conjunction with the resident's interRAI re-assessment, or as a resident's needs change. On the day of the audit there were 10 residents' interRAI assessments overdue. A plan had been put in place by the acting CSM and each of the residents' files have been allocated to an RN with an expected time frame to have these completed. (Refer criteria 1.3.3.3 and 1.3.6.1).
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness with an expiry date of 5 June 2022 is publicly displayed in two areas of the buildings. Renovations are underway in parts of the building; however, there have been no modifications to the buildings since the last audit. The manager described how some time ago the policy of using double rooms was changed and they are now only used by one resident at a time. Also, one resident's room was converted for use as an office. These actions reduced the facility's official bed capacity from 72 to 68.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified	FA	Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The infection prevention and control (IPC) coordinator reviews all reported infections, and these are documented. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared at the monthly quality and risk meeting. Results and meeting minutes are shared with staff and results are benchmarked at a national level. Infection control measures recommended by the Ministry of Health for the management of COVID-19 pandemic were implemented. A request from the Southern District Health Board in relation to the follow up of

in the infection control programme.		recommendations from infection outbreaks and the COVID-19 preparedness plan were followed-up. All recommendations and actions have been addressed and were seen to be embedded into practice during the audit.
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, include applicable definitions, and provide guidance on the safe use of both restraints and enablers. The restraint coordinator was not available for interview on the day of the surveillance audit; however, records and meeting minutes reviewed demonstrated this person has a sound understanding of the organisation's related policies, procedures and practice. Staff expressed confidence in the manner the restraint coordinator provides support and oversight for enabler and restraint management in the facility. On the day of audit, one resident was using a lap belt as a restraint when in their electric power chair and three residents were using lap belts and/or bed rails as enablers. These were the least restrictive options for them and are used voluntarily at these residents' requests. Similar assessment, monitoring and review processes are followed for the use of enablers as are used for restraints. Restraint is used as a last resort when all alternatives have been explored. Ongoing efforts to minimise the use of restraint was evident during manager and staff interviews, in quality improvement reports and in restraint approval group and quality and risk meeting minutes. However, these were no longer demonstrating continuous improvement processes are being maintained, as described during the previous certification audit.

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 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Within the quality and risk management system, corrective action processes are in place to address areas identified as requiring improvement. Examples of issues of concern being identified and corrective action plans implemented and followed through were evident in monthly clinical indicator reports to the support office, quality and risk meeting minutes and in internal audit documentation. However, the records available showed an inconsistency in the reporting channels of these and not all were being reported via the quality and risk management system. This has created a lack of clarity as to when or if some of them had been followed through or closed. There were examples of corrective actions taken or quality improvement initiatives implemented for which there was limited formal documented evidence; however, the facility manager described actions that had been taken. Examples included for the trends identified in analysed quality data, such as the number of episodes of verbal and/or physical aggression in the incident reporting system, and the meals, laundry and communication issues	Corrective action processes are not consistently being applied with examples evident of issues of concern being identified and then not followed up as a corrective action, or a quality improvement. When corrective action plans are developed, there is a lack of evidence that all are being followed through to closure, or documentation is in a	Corrective action plans are developed, implemented, and followed through to completion to ensure any shortfalls or areas requiring improvement are addressed to meet the specified standards or requirements.

		raised in the 2021 residents' survey. A corrective action has been raised due to the inconsistency of the reporting of corrective actions/quality improvements and the subsequent lack of clarity as to what actions have been taken and by whom. Also, not all identified shortfalls, had been developed into corrective actions albeit they were mostly for minor observations within the internal audit system, and many were reported as having been resolved.	different place.	180 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Low	A health and safety system is in place and ongoing reviews of risks, including of the Clutha Views Lifecare hazard register, are occurring. An overarching organisational risk management plan is available and monthly reporting systems from Clutha Views Lifecare to the support office contribute towards managing a range of risks within the facility. This process has enabled the current staffing and care planning issues to be identified and action plans to be developed. Service delivery risks are also being addressed through registered and enrolled nurse meetings and minutes sighted confirmed they are discussed at these meetings and/or quality and risk meetings. There is an organisational risk matrix with associated templates to be completed by each facility. Clutha Views has not yet completed this; therefore, does not currently have a specific facility based risk management plan/risk matrix.	Not all facility based actual or potential risks are being identified, monitored and evaluated at relevant intervals.	A facility based risk management plan/matrix that identifies all actual and potential risks, including those related to service provision, is developed and evaluated and reviewed at pre-determined intervals to assess the probability of change in the status of each risk. 180 days

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	Staff were interviewed both informally and formally throughout the audit with some interviews undertaken in pairs. Rosters were reviewed and compared with related policy documentation including one on safe staffing ratios for Clutha Views Lifecare. The facility manager and temporary clinical services manager were interviewed about staffing levels and residents and family members were specifically asked about staffing in relation to service delivery. There was evidence to demonstrate staffing levels are not always safe and appropriate and cannot always respond to the changing needs of residents: - Rosters showed that staffing levels do not always meet the documented safe staffing ratio levels - There are insufficient staff available to replace planned staff leave or last minute unplanned staff absences - When a staff person from the rest home wing relieves elsewhere this leaves hospital residents in that wing with one staff person only - The dementia service only has two staff on duty, which is not ensuring residents can be suitably supervised during at risk times, such as early evening for the management of sundowning, or during morning medication rounds/breakfast times, and does not always enable relief of staff for breaks - The diversional therapist in the dementia service is regularly requested to take on caregiving roles, thus reducing time available to assist with meaningfully occupying residents - Not all key tasks of the clinical services manager, including development and review of residents' care plans and analyses of clinical indicators, for example, are being completed within required timeframes - During interviews with three groups of care staff, all separately expressed concern and frustration over insufficient staff numbers on duty over most shifts, heavy workloads, juggling between units to relieve others, missing scheduled breaks, non-	An inability to implement the documented rosters, non-replacement of staff with unplanned absences, outstanding key registered nurse duties, insufficient staff during key times of the day, staff expressing high stress levels from lack of staff and people taking on additional tasks, were examples of factors contributing to potential and significant risks for residents. The evidence available demonstrated that staffing levels are not always safe and appropriate, therefore timely, appropriate, and safe service delivery cannot be guaranteed.	Registered nurse roles and responsibilities, and the rostering of sufficient suitably qualified/skilled and/or experienced service providers, are fulfilled at the level required to ensure safe, timely and competent service delivery. 90 days

		replacement of absent staff and lack of ongoing registered nurse support As noted in standard 1.2.4, in response to District Health Board actions regarding a report to the Health Integrity Line, remedial actions are underway. The commitment to these changes by the facility manager, the regional and quality managers from the HLL support office and the manager of another HLL facility was evident. Progress to date showed enrolled nurses are now team leaders for each of the service areas of rest home, hospital and dementia care. A recruitment drive is underway and additional staff have already been employed, including two registered nurses who have just completed their orientation. This is intended to ensure the safe staffing ratios roster will be maintained. Extra staff training is being provided and focuses on issues of concern. The facility manager informed they have been increasing their presence around the building and this was confirmed by staff. A temporary clinical services manager had been employed while the usual person is on leave. Duty lists have been developed to complement job descriptions and to clarify role differentiation. Proposed roster changes to use staff more effectively and to increase staffing numbers both in the morning and evening in the dementia service are currently with the management team at support office date. Such interventions contributed to the risk level of the corrective action for this standard being moderate, rather than high risk. The DHB portfolio manager has been alerted to the staffing concerns by both the facility manager and the auditor.		
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	Review of the electronic medication management system demonstrated not all requirements are being met. The electronic system and discussion with the registered nurse demonstrated only one registered nurse is checking and signing in the residents' monthly blister packs on the electronic system. The last GP medicines review date alert was indicated on several files reviewed, suggesting that they have not been reviewed within the required timeframe. The typed resident review list did not match	Not all aspects of medication management meet requirements: - Pharmacy packs are not always being "checked" into the electronic	All aspects of the medication management system reflect current legislation and accepted best practice guidelines.

		the electronic information. A system is in place to record the opening dates on pharmaceutical items, such as eye drops, ear drops and inhalers. However, not all opening dates are being recorded. Staff administering medications all have a current medication competency; however, the clinical services manager responsible for overseeing these assessments does not have a current competency.	medication system. - GP three monthly review dates do not accurately reflect the expected times frame on the electronic records. - Dates were not documented on one box of eye drops and one inhaler to show when they were opened. - An up-to-date medication competency was not evident in the file for the clinical services manager who is responsible for assessing staff medication at Clutha Views Lifecare & Village. The last date of a competency review on file was for 2016, they had completed and insulin administration update in 2021.	90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision,	PA Moderate	There was evidence of the use of various assessment tools, for example, for behaviour, falls, pressure injury risk, pain assessments, amongst others. However, there was no evidence of consistent use of an admission nursing assessment tool and there were only three	InterRAI assessments and Long-Term Care Plans are not being completed within 21	All residents have a current interRAI assessment,

evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		interRAI assessments completed in the six files reviewed. Long term care plans were not completed in two of the tracer files that were reviewed. The absence of care plans does not ensure that the needs of the resident are being met. The acting clinical services manager has identified this as an issue and has allocated residents to each of the registered nurses to complete these. At the time of the audit there were 10 residents whose six monthly interRAI reviews were overdue.	days of admission as required by the Aged Related Care Agreement (D16.2b) and nor was there any evidence of an interRAI assessment being used at six monthly intervals for review purposes.	and Long-Term Care Plans are completed within the required 21-day time frame. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Examples of wound care plans were viewed. Diversional therapy plans were in all residents' files sighted inclusive of 24-hour activities for residents with dementia. No long-term service delivery/care plans were evident in four out of six files reviewed, and therefore insufficient evidence was available to evaluate the residents' care and determine if their needs were being met. Summary care plans were sighted in three out of six electronic files. Staff informed during interviews that they no longer have care plans to refer to as the registered nurses do not have time to complete these. (Refer criterion 1.2.8.1).	There was insufficient evidence in the service delivery/care plans in four of the six files reviewed to ascertain the care requirements for these residents.	All residents' service delivery/care plans are up to date and reflect the residents' assessed needs and desired outcomes. 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 Moderate	Comprehensive daily progress notes were evident in residents' electronic files. There was no evidence of interRAI re-assessments in three out six files reviewed. Long term care plans were not available in four out of six files reviewed, therefore evaluations and reviews of achievements and responses to interventions cannot be measured. For those residents that did have long-term up to date interRAI assessments and long-term care plans, these were evaluated, along with short term care plans within the appropriate time frames.	In the absence of comprehensive long term care plans, there was a lack of evidence that residents' care was being consistently evaluated to measure achievement or response to planned interventions and outcomes.	Residents' care plans are evaluated and reviewed at least every six months, or when clinically indicated by a change in their condition.

				90 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.