

Heritage Lifecare Limited - Granger House 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:	Granger House Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 December 2021 End date: 3 December 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:	62

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

Granger House Lifecare provides rest home and hospital level care including respite, end of life and care for people with long term conditions. The service is operated by Heritage Lifecare Limited (HLL) and presently managed by a roving acting care home manager pending advertising to appoint a new manager. A new clinical services manager commenced two weeks prior to this certification audit. The service has been operating without a clinical services manager for some months and this role is now being re-established. Although there have been changes of management over recent months, 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 West Coast District Health Board (DHB) and the Ministry of Health (MoH). The audit process included review of policies and procedures, review of residents' and staff files, inspection of the environment and interviews with residents, family members, managers, staff, visiting health providers and a nurse practitioner.

This audit has identified two areas requiring improvement relating to staffing and completing the upgrade of the environment and equipment.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Granger House Lifecare when they are admitted. Opportunities are provided to discuss the Code, consent, and availability of advocacy services at the time of admission and thereafter as required.

Services are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for any residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required and bi-lingual staff.

Granger House Lifecare has linkages to a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained. Information about the complaints process is provided at the time of admission and is available at the front entrance. The new management team now ensure complaints are being fully investigated and responded to in accordance with policy.

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 low risk.
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Strategic, business and quality and risk management plans have been developed for Heritage Lifecare Limited. These include the purpose, direction, goals, and values of the organisation. Regular monitoring of the services occurs, with analysis and regular reporting to the governing body monthly. An experienced and suitably qualified person is providing management cover to the facility.

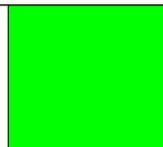
The quality and risk management systems include collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is regularly sought from residents and families. Adverse events are documented with corrective actions implemented where required. Actual and potential risks, including health and safety risks, are identified, managed, and mitigated. Policies and procedures are centrally managed by HLL and are current to support service delivery to residents.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review for all staff groups. Staffing levels and skill mix has been challenging with a shortage of registered nurses including, until recently, a clinical services manager.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

Resident admission to the facility is appropriate and efficiently managed with liaison evident between the Complex Clinical Care Network and the clinical team. Relevant information is provided to the potential resident and their family to facilitate admission to the facility.

The residents' needs are assessed by the multidisciplinary team on admission and within the required time frames. Care plans are individualised, based on a comprehensive range of information, and accommodate any new problems that might arise. The residents' files reviewed evidenced that the care provided, and the needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health providers as required. Shift handovers and communication sheets promote continuity of care between the shifts in the rest home and hospital.

The planned activity programme is delivered by one part time diversional therapist and one full time activities assistant, spread across the two clinical areas. The rest home and hospital residents have a separate activities programme which provides a variety of individual and group activities and maintains the residents' links with the community. There is a facility van available for outings.

Medicines are managed according to the policies and procedures which are based on current best practice and consistently implemented. Medications are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with any special requirements catered for. There is food available for rest home and hospital residents 24 hours a day. Policies guide the food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents and families verified satisfaction with the meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The facility meets the needs of residents and was clean and comfortable. A major refurbishment and equipment upgrade is underway. There was a current building warrant of fitness displayed. Electrical and biomedical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating for residents.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing where indicated. Chemicals are safely stored. Laundry is undertaken onsite and is collected and handled safely. Cleaning and laundry services are monitored for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular trial fire evacuations. There are adequate pandemic supplies on hand. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Five enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Three restraints were

also in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs for all restraints. 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.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed if required.

Staff demonstrated good knowledge around the principles and practice of infection control, guided by relevant policies and supported with regular education.

Age care specific infection surveillance is undertaken, with data analysed, benchmarked and results reported through to all levels of the organisation. Follow up action is taken as and when required.

Covid-19 related processes are in place to manage the changes in the Ministry of Health Covid-19 response levels.

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	48	0	2	0	0	0
Criteria	0	99	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Granger House Lifecare has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). This is displayed throughout the facility in both English and Māori and residents receive a copy of this in the admission pack. 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 compulsory for all staff as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principals and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs and outings. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents is defined and documented, as relevant, in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed gaining consent for day-to-day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and Brochures related to the service are on display in the reception area of the facility. Family members and residents spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff are also aware of how to access the Advocacy Service if this is required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment as current Covid-19 restrictions allow. The facility encourages visits from family and friends and family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns/issues policy and associated forms which are part of the HHL system meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission.</p> <p>The complaints register reviewed showed that four complaints have been received since March 2021. Actions had been documented for one of these complaints through to an agreed resolution under the new management team. This team demonstrate their understanding of requirements and have implemented complaints management in accordance with the organisation's policy. A previous complaint had no resolution recorded. Documentation for two others could not be located in the manual system, to confirm that timeframes and outcomes had been met. The staff involved are no longer employed in the facility and no further information could be located. However, the most recent complaint has been appropriately managed.</p> <p>The care manager is responsible for complaints management and follow up. The temporary roving care home manager has been filling the management role for two months and no complaints have been received in this period. The processes were well understood and described. One action plan reviewed showed required follow up and improvement, including training has occurred.</p> <p>Staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There is one outstanding Health and Disability Commissioner (HDC) complaint on behalf of the coroner for both Granger House and another agency. Information has been provided and the service is presently awaiting follow up from the HDC.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>When interviewed, the residents and family/whānau of Granger House Lifecare, reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in English and Māori at the reception and throughout the facility and each resident has a copy of this in the admission folder. Information on how to make a complaint and provide feedback is available and displayed in the reception area.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and their families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understand the need to maintain privacy and were observed doing so throughout the audit when attending to the personal cares of residents, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families. All residents have a private room with communal facilities nine rooms have private ensuite facilities. There are several lounges located throughout providing quiet areas to chat away from the main communal areas.</p> <p>Residents are encouraged to maintain their independence by participating in activities within the facility and outside in the community as Covid-19 allows. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs have been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to be occurring during the orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There is currently one resident at Granger House Lifecare that identifies as Māori. Staff receive annual education to enable them to support residents who do identify as Māori to integrate their cultural values and beliefs. The principals 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 and guidance on tikanga best practice is available. There are staff who identify as Māori in the facility and can act as a resource.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Staff can access an external interpreter service for residents if required and several staff members are bi-lingual. Residents' personal preferences required interventions and special needs were included in all care plans that were reviewed. For example, likes and dislikes and attention to preferences around activities of daily living. Residents' survey results evidenced that the residents' needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. One of the facility nurse practitioners who was interviewed also expressed satisfaction with the standard of services provided to the residents. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service provides and encourages good practice, this is demonstrated through evidence-based policies, input from external specialist services and allied health professionals, for example, palliative care, district nurses, dieticians, podiatrist, and education for staff. The NP confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported that they receive management support for external education and access their own professional networks.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, they are advised in a timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the residents' records that were reviewed. There was also evidence of resident/family input into the care planning process and the multi-disciplinary meetings.</p> <p>Staff understood the principals of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access an interpreter should this be required, and several staff members are bi-lingual.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The HLL strategic and operational plans are regularly reviewed at national level, and these are implemented locally. The current Granger House quality plan outlines three key goals to be achieved during the year. These goals relate to the refurbishment of the facility, falls prevention and establishing stable staffing. A sample of weekly/monthly and quarterly reports were reviewed and confirmed that clinical indicators and non-clinical performance is routinely monitored and reported to the board of directors. Adequate information is provided including financial performance, emerging risks, and service issues. Operational performance reports (sent to the HLL support office) were viewed and included details such as occupancy, staffing reports, complaints, incidents/adverse events, infections and restraint use.</p> <p>The service is presently managed by a roving care home manager, who initially provided cover for the vacant position of clinical services manager, but more recently has covered the care home manager responsibilities pending advertising for this role. The temporary manager has four years' experience in similar roles and holds relevant nursing qualifications. Short term responsibilities and accountabilities were described and there is a job description and individual employment agreement developed for the recent appointment to the care manager role. Two regional managers present and interviewed during the audit (the regional quality manager and operations manager) confirmed that support is provided for the roles, including for the new clinical services manager. The care home manager confirmed knowledge of the sector, the regulatory and reporting requirements and maintains currency through regular input by the HLL management team, professional networks, and external training courses.</p> <p>The service holds contracts with the West Coast DHB for aged residential care, respite, complex medical conditions, and palliative care. There are no ACC or YPD residents presently residing at Granger House. Sixty-two residents were receiving services under these contracts on the days of audit – 36 hospital level care and 26 rest home level care residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>HLL has a national infrastructure that provides cover during extended absences for both the clinical and the care manager. The temporary care home manager has been on site for approximately nine weeks at the time of the audit and the recruitment phase for the role is commencing. Regional managers provide additional support for the service during the recruitment, appointment, and orientation phase for new managers.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, a regular care home satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint use.</p> <p>A variety of internal meetings are held, either on a monthly or quarterly basis. These include staff meetings, registered nurse, resident, household and quality/infection control/health and safety and restraint meetings. A sample of minutes were reviewed for these and confirmed discussion and reporting of clinical indicators including complaints are recorded. Staff reported their involvement in quality and risk management activities through internal audit activities, and changes in policies.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Care home customer experience surveys are completed annually, the most recent being June/July 2021. This includes net promotor scores for the service. Results are benchmarked across HLL. The most recent survey showed Granger House is below the benchmark for management of complaints and concerns and for its meal service. Since then, a further specific survey has been undertaken to explore meal service satisfaction, and this continues to be monitored.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool. Policies are based on best practice and were current, following a major review which commenced in December 2020. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. Granger House has hard copy policy manuals readily available to staff.</p> <p>There has been a recent 'catch up' of the scheduled internal audits, mostly achieving 100% compliance with only a few minor deficiencies noted. HLL undertake a facility health check in the period leading up to an external audit. This has been useful in providing the management team with a quality workplan, which is progressing according to the priorities and risk ratings applied.</p> <p>Systems and processes are in place for the identification, monitoring, review and reporting of risks, including health and safety hazards and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed, and reported at the staff and quality meetings. Summary results are collated by the care home manager, entered into the electronic system (eCase) and sent to the HLL head office each month. Hard copy</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>reports were completed and signed off, including any follow up actions required.</p> <p>The care home manager described essential notification reporting requirements, including for pressure injuries. Since July 2021, there have been nine Section 31 notices submitted to the Ministry of Health for a variety of events including registered nurse shortages, episodes of resident aggression, (including one resulting in injury involving police intervention), self-harm incidents and a stage three facility acquired pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of twelve staff records reviewed confirmed the organisation's policies are being consistently implemented and both hard copy and electronic records are maintained for staff.</p> <p>Continuing education is planned by HLL throughout the year, including mandatory training requirements. Staff report opportunistic in house 'toolbox' sessions are a frequent occurrence on topics of interest. 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 DHB. Presently there is no staff member who is a designated internal assessor for the programme, however the roving care manager is qualified to undertake this. Plans are underway to ensure assessment needs can be met internally.</p> <p>There are two trained and competent nurses who are maintaining their annual competency requirements to undertake interRAI assessments. One RN has almost completed the assessment, and the clinical services manager is booked to commence in January 2022. Three assessments were overdue, but scheduled, and a further one is underway.</p> <p>Staff orientation includes all necessary components relevant to the role including clinical skills and a buddy. Staff records reviewed showed documentation of completed orientation and a performance review after a three and six-month period and annually thereafter. Appraisals are up to date except for two scheduled for December. Twelve staff records reviewed confirmed the organisation's policies are being consistently implemented and records are adequately maintained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	<p>PA Low</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. Most recently, this has involved relocating hospital level care residents to be concentrated in one wing of the facility, to help maximise the registered</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>nurse cover. Although the whole facility offers 'swing beds', there are presently only four of 36 hospital level care residents remaining in other areas of the facility and as able, they will also be moved into this area. Hospital level care admissions are presently on hold.</p> <p>An afterhours on call roster is in place, shared between the roving manager and the clinical services manager. Registered nurses cover all shifts with staff reporting that good access to advice is available when needed. Residents and family members interviewed supported this. Review of a four two-week roster cycles dating back to August 2021 confirmed most shifts are covered, or if necessary, staff will do a longer shift to provide adequate cover. Where unfilled gaps appeared on the roster, a further check was made with the payroll system to confirm whether these shifts had been claimed. With three exceptions, this had occurred. Casual staff may be used to cover any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with NP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records are legible with the name and designation of the person stamped beside the entry.</p> <p>Archived records are held securely on site and are readily retrievable. They are held for the required period of time before being destroyed. No personal or private resident information was on display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents are admitted to Granger House Lifecare following assessment from the Complex Clinical Care Network, as requiring the levels of care that Granger House Lifecare provides. Prospective residents and their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. All residents are admitted to the facility in accordance with current MoH Covid-19 guidelines.</p> <p>Family members interviewed stated that they were happy with the admission process and the information that had been provided to them. Files reviewed contained the completed demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner. The service uses the DHB 'Yellow Envelope' system to facilitate the transfer of residents to and from acute care settings. There is open communication between all services, the residents, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, is provided for ongoing management of the resident. All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The Medication Management Policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse signs in the medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as 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 and accurate entries with controlled drugs signed in. All registered nurses are competent with syringe drivers.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of temperature records taken.</p> <p>Good prescribing practices were noted, these 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 NP review was consistently recorded on the medicine chart. There were no standing orders or verbal orders. Vaccines are not stored on site. Residents have received the required Covid-19 vaccines except for those who did not want to be vaccinated.</p> <p>There is a documented process for any residents self-medicating. This is decided in conjunction with the NP, RN and the resident. Self-medication documentation is completed by the GP and a copy is placed in the notes. At the time of the audit there were two residents self-medicating in the 18 files reviewed.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site with a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician in November 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries (valid until 17 January 2022). At the time of the audit, the kitchen was observed to be clean. The cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan using a paper base recording system.</p> <p>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. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and families/whānau interviews, satisfaction surveys and in residents' meeting minutes. There are a selection of snacks and sandwiches for residents 24 hours a day. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received, but the resident does not meet the entry criteria, there are no vacancies, or the referral has been declined from the service due to inappropriate referral from the Complex Clinical Care Network, there is a process in place to ensure that the prospective resident and family are supported to find an appropriate level of care. Examples of this occurring were discussed with the clinical manager.</p> <p>If the needs of the resident change and they are no longer suitable for the services offered a referral for reassessment is made to the Complex Clinical Care Network and a new placement is found in consultation with the resident and the whānau/family.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	<p>FA</p>	<p>On admission, residents at Granger House Lifecare are assessed using a range of nursing assessment tools, such as, a pain scale, falls risk, skin integrity, cognition and behaviour, nutrition, and activities, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI tool, in conjunction with additional assessment data,</p>

manner.		<p>occurs every six months or more frequently as residents changing conditions require.</p> <p>Interviews, documentation, and observation verified the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans at Granger House Lifecare are paper based. The files reviewed reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly documented, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and family/whānau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals, and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The NP interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the NP should a resident's condition change. Medical orders are followed, and residents care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation and they have the opportunity for input into care planning.</p> <p>A range of equipment and resources were available and suited to the levels of care provided and in accordance with the resident's needs, such as pressure relieving devices.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	FA	<p>The activities programme is provided by one part time qualified diversional therapist who works in conjunction with a full-time activity's assistant. They support the rest home and hospital residents Monday to Friday 8.00 am till 4.00 pm Monday to Friday. Activities and movies are available for the residents at the weekends with the support of the carers.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate a</p>

<p>service.</p>		<p>plan that is meaningful to the resident. The activities are evaluated and form part of a six-monthly multidisciplinary care plan review.</p> <p>There is one resident who identifies as Māori, and they are greeted in their native tongue and support is given for activities culturally appropriate for them. It is the aim of the diversional therapists to get the residents engaging in the community as much as possible. There is a facility van available for drives in accordance with current Covid-19 restrictions.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'Housie', knitting and visiting entertainers prior to the Covid-19 restrictions. There is individual, group and gender specific activities for female and male residents. Hospital and rest home residents have a separate activity programme but come together for some of the group activities. There are several lounge areas, as well as the individual's bedrooms where they have the opportunity to watch their own television or listen to the radio. The activities calendar is on display and each resident is given a copy of the monthly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular basis.</p> <p>Residents and families can evaluate the programme through day-to-day discussions with the activities co-ordinator and by completing the six-monthly resident satisfaction survey and the six monthly multi-disciplinary meeting. Residents interviewed confirmed the programme was interesting and varied.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessment and the multi-disciplinary team meeting, or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans are consistently reviewed for infections, pain, weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the NP sends a referral to seek specialist input. Copies of referrals were sighted in the residents' files. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews.</p>

<p>referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>Any acute/urgent referrals are attended to immediately, such as ringing an ambulance if the situation dictates.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff were observed to follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is no designated chemical handler as chemical quantities are low.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and used, including the laundry. Staff interviewed knew what to do should any chemical spill/event occur. A spill kit is available in the laundry.</p> <p>There is provision and availability of protective clothing and equipment, and staff were observed using this correctly.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>A current building warrant of fitness (expiry date 1 July 2022) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. A major refurbishment is underway, including bathroom improvements where non-intact surfaces, and worn carpets were noted. (Refer CAR 1.4.2.4). Old and damaged equipment is being replaced, commencing with seven new electric beds to replace those that are no longer functional. A full repaint is planned for one wing.</p> <p>The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free and resident safety was promoted.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes ensembles for most of the hospital wing rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>

requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move safely around within their bedrooms. Rooms in the hospital are generally larger to facilitate use of mobility aids, hoists and two staff. There is a double room awaiting admission for a married couple. Bedrooms otherwise provide single accommodation.</p> <p>Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is space to store mobility aids and wheelchairs. Several residents have mobility scooters; however, these are generally stored safely away from foot and wheelchair traffic.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available throughout the facility for residents to engage in activities of their choosing. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. Some furniture replacement is underway including bedside tables (Refer 1.4.2.4).</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There is a small cleaning team who have received appropriate training and provide facility cleaning over the seven-day period. These staff are experienced and understand the correct principles of cleaning in a health care facility. Chemicals are provided by a contracted company who also provide regular chemical training for staff. Chemicals were stored in a lockable cupboard in the cleaning rooms and were in appropriately labelled containers. Refilling occurs using a closed system.</p> <p>Laundry is undertaken on site in a dedicated laundry area. Family members also undertake personal laundry if they wish. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow, and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and the annual care home survey.</p>
<p>Standard 1.4.7: Essential,</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response systems were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for</p>

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>disasters and described the procedures to be followed in the event of a fire or other emergency. The care home manager has attended meetings with the DHB to plan for local emergencies and disasters, including pandemic planning.</p> <p>The current fire evacuation plan was approved by the Fire and Emergency New Zealand (FENZ) in 2012. However, the regional manager reports that an application is underway to FENZ for this to be updated and for checks on the system to be included in this. Trial fire evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on September 2021 and March 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. First aid certificates are held by senior staff rostered in the facility and for the diversional therapists and maintenance personnel who take residents off site.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food for at least two weeks, a 5000-litre potable water tank, blankets, mobile phones and two generators which meets the National Emergency Management Agency recommendations for the region. Emergency lighting is regularly tested. There are adequate and well organised pandemic supplies on hand.</p> <p>Call bells alert staff to residents requiring assistance. The older system does not allow call bell response times to be checked, however staff were observed to respond promptly. Delays in call bell responses had featured in a complaint earlier in the year, but residents and family spoken to during the audit did not identify any current issues.</p> <p>Appropriate security arrangements are in place, with the facility locked down at night. Presently the facility has one entry point to manage visitors during Covid-19 restrictions.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are electrically heated and ventilated appropriately. Rooms have natural light and opening external windows. There are a variety of sheltered spots for residents to sit outside as they wish, including a designated smoking area. Heating is provided by electric thermostatically controlled wall mounted heaters in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and reported to be maintained at a comfortable temperature for residents.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers,</p>	<p>FA</p>	<p>Granger House implements an infection prevention and control programme to minimise the risk of infection to residents, staff, and visitors. A comprehensive and current infection control manual is available to staff and managers. There is evidence that formal reviews of the programme are completed annually.</p> <p>The clinical nurse manager is the designated infection prevention and control co-ordinator, whose role</p>

<p>and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and reviewed at the monthly quality committee meetings. Infection prevention and control matters are also discussed at registered nurse meetings, staff handovers, staff meetings and ultimately at management meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities and confirmed this had been further reinforced since the Covid-19 pandemic emerged with a documented process for each of the alert levels.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICN has the appropriate skills, knowledge, and qualifications for the role. Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the NP and the public health unit, as required. The co-ordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>There is a Covid-19 management plan in place which details all the actions required by the service streams within the facility in response to each of the alert levels. The ICN and the quality manager confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing and clearly documented on each policy is the next review date. 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, as was appropriate to the setting. Hand washing and sanitiser dispensers are distributed around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p>	<p>FA</p>	<p>Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and in ongoing education sessions. Education is provided by</p>

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>suitably qualified RNs and 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.</p>
<p>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.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract, and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at staff meetings and during shift handovers. A good supply of personal protective equipment was available, and Granger House has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>HLL 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 RN restraint coordinator, who has been in the role for two months, provides support and oversight for enabler and restraint management in the facility. The restraint coordinator demonstrated a sound understanding of the organisation's policies, procedures and practices including the role and responsibilities.</p> <p>On the day of audit, three residents were using restraints. Five residents were using enablers. These were the least restrictive and used voluntarily at the residents' requests. A similar process is followed for the use of enablers as is used for restraints. Restraints approved for use include a fall out chair and bed rails.</p> <p>Restraint is used as a last resort when all alternatives have been explored, and when the resident is unable to consent to their use, to support safe care. This was evident on review of the restraint group minutes, files reviewed, observation and from interviews with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of</p>	<p>FA</p>	<p>The restraint group are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint meeting minutes, residents' files, and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. All restraints presently used have been</p>

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.		approved and have been reviewed over an extended period. Evidence of family/whānau/ person with enduring power of attorney (EPOA) involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the documented 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 each restraint were documented and included all requirements of the standard. The RN undertakes the initial assessment with the restraint coordinator’s involvement, as well as input from the resident’s family/whānau or person with enduring power of attorney. The RN interviewed/restraint coordinator described the documented process. The general practitioner or nurse practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives, and associated risks. The desired outcome was to ensure the resident’s safety and security. Completed assessments were sighted in the records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats (initiated from admission and assessed for continued use), low beds and floor mattresses). When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details and has recently been improved with the introduction of a new more detailed monitoring form. Access to advocacy is provided if requested and all processes during restraint use ensure dignity and privacy are respected. A restraint register is maintained, updated every month, and reviewed at each restraint group meeting. The register was reviewed and contained all residents currently using a restraint and enough information to provide an auditable record. Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to keep people using restraint safe.
Standard 2.2.4: Evaluation Services evaluate all episodes of	FA	Review of residents’ files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint group meetings.

restraint.		<p>Family members interviewed did not have a resident presently using a restraint.</p> <p>The evaluation covers all requirements of the standard, including future options to eliminate use, the impact and outcomes achieved, whether the policy and procedure was followed and completion of the documentation.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>A six-monthly review of all restraint use, which includes meeting the requirements of the standard, is undertaken. Six monthly restraint meetings and regular reports are completed. Individual use of restraint use is reported to the quality and staff meetings.</p> <p>Minutes of meetings reviewed confirmed this included 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 restraint / enabler education and feedback from the doctor, staff, and families.</p> <p>A six-monthly internal audit also informs these meetings. Any changes made by HLL to policies, guidelines, education, and processes are implemented as required. Data reviewed, minutes and interviews with staff and the coordinator confirmed that the use of restraint has remained static over several months.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Rosters are in place to staff all areas of the facility. However, staffing levels have been under pressure in recent months for a combination of reasons including but not limited to:</p> <ul style="list-style-type: none"> - Four staff are on long term ACC and are unable to be permanently replaced. - Difficulty recruiting RNs in the region has resulted in a temporary moratorium on further hospital level care admissions to the facility. - Hospital level care residents have been relocated to the hospital wing to maximise registered nurse cover into one area. - The service has consistently been reflecting more hours delivered than budgeted, however, this is necessary 	<p>Overall, staffing levels remain challenging, with ongoing difficulties recruiting registered nurses in the region. Together with gaps between appointments of clinical services manager and a recruitment process underway for the care home manager, temporary arrangements are in place utilising an HLL roving care home manager. Further efforts are needed to successfully recruit and retain staff to ensure safe and sustainable staffing levels. Staffing levels and skill mix remains a risk for the service.</p>	<p>Continue to successfully implement recruitment efforts to ensure sustainable safe staffing levels and skill mix.</p> <p>180 days</p>

		<p>to reflect the extended layout and available skill mix.</p> <ul style="list-style-type: none"> - One RN has resigned and is due to finish the week following audit, adding further pressure to the roster. A registered nurse is due to return from maternity leave in February 2022. <p>Staff interviewed indicated the need to work longer hours or more shifts than usually rostered. Care staff reported that the acuity has increased in the hospital area with more residents moved to the area (eg, a greater number of hoist transfers requiring two people are now more concentrated in this area), and at times they struggled to complete the work allocated to them. Additional resource was not always available. Although staff report feeling tired, there have been no additional workplace injuries recorded over recent months. The care home manager and clinical services manager will, if necessary, cover the morning roster shift to ensure safe staffing. Afternoon and night shifts were fully covered by RNs in the roster sample.</p> <p>Some mitigation strategies are in place to manage this effectively and reduce the risks; however, it will take time for the service to be fully staffed with an appropriate skill mix. Recruitment efforts are continuing, including for a care home manager, RNs, and caregivers.</p>		
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to</p>	PA Low	<p>The service has embarked on major refurbishment of the environment at Granger House. While planning is underway, funds allocated and quotes obtained, the programme will take some months to complete to ensure a safe environment for residents.</p> <p>This includes but is not limited to:</p> <ul style="list-style-type: none"> - Replacing worn and stained carpet and vinyl, - repairing doorways and walls damaged from wheelchairs and other equipment, 	<p>Work is underway to improve safety of the physical environment for residents as part of a major refurbishment in older parts of the facility. This will take some months to fully complete.</p>	<p>Complete the planned improvements designed to create a safe environment for residents.</p> <p>180 days</p>

<p>the needs of the consumer/group.</p>		<ul style="list-style-type: none"> - upgrading bathroom floors and walls to ensure surfaces are intact to maintain infection control. - The programme to replace older equipment including electric beds throughout and dining tables in one wing. - Heat pumps to maintain stable temperatures in the medication rooms <p>This is work in progress which has only just commenced, with seven new beds installed.</p>		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.