Heritage Lifecare (BPA) Limited - Highfield Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare (BPA) Limited
Premises audited:	Highfield Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 February 2018 End date: 14 February 2018

Proposed changes to current services (if any): A sale and purchase agreement to a new provider

Total beds occupied across all premises included in the audit on the first day of the audit: 38

Executive summary of the audit

Introduction

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

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

General overview of the audit

Highfield Rest Home provides rest home level care for up to 44 residents. The service is operated by BUPA and managed by a care home manager and a clinical manage. Residents and families spoke positively about the care provided.

This provisional 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.

This facility is being sold and this provisional audit is being undertaken to establish the prospective owner's preparedness to provide a health and disability service and the current level of conformity with the required standards. A sale and purchase agreement with the prospective provider, Heritage Lifecare (BPA) Limited, is anticipated to be enacted in April 2018.

This audit has resulted in identified areas requiring improvement relating to complaints and water temperatures.

Consumer rights

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

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

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

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

A complaints management system is in place.

Organisational management

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the 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 corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff 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. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

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

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

Medicines are managed and administered by staff who have completed a medication competency to do so.

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

Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no restraints were in use at the time of audit. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	2	0	0	0
Criteria	0	91	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy with residents. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff and include advance care planning, and establishing and documenting enduring power of attorney requirements. Processes for residents unable to consent are defined and documented. Clinical files reviewed showed that informed consent has been gained using the organisation's standard consent form. Where a resident is deemed incompetent to make an informed choice the enduring power of attorney

		(EPOA) will consent on behalf of the resident. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical manager was able to provide examples of when the Advocacy Services would be encouraged and the different resources that are available to residents and family in the community.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. However, the complaints register is not current or complete and this needs improvement. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints register reviewed showed that two complaints have been received over the past year; one being a Health and Disability Commissioner (HDC) complaint, is still on-going, and documentation sighted verified that responses to the HDC have been within required timeframes. The other complaint showed that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. An action plan shows any required follow up and improvements have been made where possible. The care home manager

		(CHM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family members interviewed 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 discussion with staff. The Code is displayed in the main foyer of the facility together with information on advocacy services, how to make a complaint and feedback forms. The prospective provider is an experienced aged care sector provider. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the requirements of the Code as part of their existing roles.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor, and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence, for example accessing regular community activities, and how this is achieved and what supports are available and utilised. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Residents reported that staff knock on their doors and wait for acknowledgement before entering the room. Residents are encouraged

		and supported to personalise their bedrooms. Residents and their visitors have options of privacy in several different lounges and chair settings.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The clinical manager interviewed stated that there were currently no residents who affiliated with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori, with staff able to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi as documented in the policy are incorporated into day to day practice, as is the importance of whanau. There is no specific current Māori health plan, however all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and evidenced in the care summary, 'Map of life', identified in the interRAI assessment and integrated into long-term care plans with input from a Maori advocate located at the DHB as required.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's individual personal preferences, required interventions and special needs were included and integrated into all care plans reviewed. The resident satisfaction survey confirmed that 42% of residents felt that the cultural and spiritual needs individual needs provided by the staff are excellent and 35% of residents stated that their needs provided by staff were good.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. One of seven general practitioners who work at the service interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their/their relative's status, 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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English, staff able to provide interpretation as and when needed, and the use of family members. The clinical manager interviewed was able to provide an example of a resident who is legally blind and is supported by the use of talking books with staff ensuring that all verbal communication is clear, easy to understand and the resident is not rushed in cares and/or communication provided. Another example was of a past resident who was admitted to the facility for six weeks of respite care and was unable to speak or understand English. Family were encouraged to be part of her ongoing care, cue cards were utilised, and at the time, a staff member was able to speak and understand some of the resident's language. The residents and families interviewed confirmed that the staff know the residents well and can respond to the residents' non-verbal cues appropriately and support the residents' needs.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. A sample of monthly and quarterly reports to the board of directors showed adequate information to monitor performance is reported including occupancy rates, staffing numbers, emerging risks and issues, incidents and accidents, concerns and complaints. The service is managed by a CHM who holds relevant qualifications and has been in the role for three years, prior to that she has been in management roles in the aged care sector for many years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CHM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through professional development aged sector meetings. The service holds contracts with the South Canterbury DHB for respite and rest home level care. Thirty-eight residents were receiving services under the contract at the time of audit. There were no respite residents. New Provider Interview January 2018: The new provider is Heritage Lifecare Ltd (HLL) which is an established New Zealand aged care provider, currently operating more than 1100 beds in the sector. An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017). As of 30 January 2018 HLL has set up a new company to acquire and operate this group of new facilities. This company is Heritage Lifecare (BPA) Ltd. For ease of reference the new provider is referred to as Heritage Lifecare Limited (HLL). The transition plan is led by an experienced and well-qualified project team who are specifically focussing on the integration of the current facilities into the Heritage Lifecare Ltd group. This includes provision of infrastructure support such as providing information technology capability including hardware and software. Regional workshops are planned to introduce documentation, and the new HHL systems and processes. This is planned to occur within the first three months. The project team is

		working with the BUPA team to ensure a smooth transition of each operation. It is expected that the senior team and existing staff will remain in place at each facility. The prospective purchaser has notified the relevant District Health Board prior to the provisional audits being undertaken.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	When the CHM is absent, the clinical manager carries out all the required duties under delegated authority, or the organisation will provide cover from within the organisation. During absences of key clinical staff, the clinical management is overseen by one of two other registered nurses who are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. New Provider Interview January 2018: The prospective provider is not planning any staffing changes. Existing cover arrangements for the day to day operations will remain in place, with access to regional operations managers. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.
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.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and adverse events. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and attendance at meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed residents would like more exercise/walks outside. The

		service, as a result, introduced a daily exercise programme including regular walks outside. 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. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The CHM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. New Provider Interview January 2018: During the transition phase, HLL policies and procedures will be introduced. By the end of 2018, a new software system will be introduced to incorporate risk management including adverse event reporting, care planning and client management. Meanwhile, the electronic BUPA system will be superseded by HHL documentation and will be reliant on hard copies on site until the electronic system is fully implemented. This is anticipated to be within six months of the purchase. HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes Internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure. A key strategy to introduce a national clinical governance group is planned in the next 12 months.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	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 on the electronic reporting system that is then

		managed by head office. The CHM described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, DHB since the previous audit. New Provider Interview January 2018: There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The national quality manager interviewed could verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.
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 prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and then annually. Continuing education is planned on an annual basis, including mandatory training requirements. 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. A staff member is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability	FA	There is a documented and implemented process for determining staffing

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		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, as indicated by acuity and interRAI assessment outcomes. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. New Provider Interview January 2018: The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the Guidelines for safe staffing level and indicators. The representative for HLL interviewed could confirm understanding of the required skill mix to ensure rest home care residents needs are met. The organisation already provides the range of levels of aged care (geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. The administrator interviewed stated that she is presently reorganising older archived records to match the current database. All archived records are held securely on site and are readily retrievable using a cataloguing system
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent,	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service

equitable, timely, and respectful manner, when their need for services has been identified.		Coordination (NASC) Service. The clinical manager interviewed reported that at times she will visit the potential new resident while still in an acute setting (if applicable), to ensure that they have all the required information and can provide the care provided. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information (verbal and written) that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example of a patient transferred to the local acute care facility showed the use of the 'yellow envelope' and supportive documents. Family of the resident reported being kept well informed during the transfer of their relative.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy was 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 are deemed competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks 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. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include 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 consistently recorded on the medicine chart. There are six residents who self-administer medications at the time of audit. All six residents had an assessment completed to assess for competency of self-administration of medication. The assessment was signed by the admitting RN and GP at the time, and subsequent assessments have been completed three monthly. The RN has evidenced that the resident is asked each morning if they have taken their medication and this was recorded. Observation on day one of the audit, showed that all six residents were not storing their medication (inhalers) in a secure location; however, on day two of the audit all six residents were observed to have locked boxes in their bedrooms. The clinical manager provided a tool box session at staff handover to ensure staff knowledge regrading requirements of safe medication storage for residents self-administering medications. There is an implemented process for comprehensive analysis of any medication errors. The previous audit identified an area for improvement to ensure that the facility did not stock non-prescribed medications. The corrective action is now addressed and all medications at the time of audit were observed to

		be prescribed by the GP.
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 by two cooks and a 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. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local council and expires 22 September 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meetings minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The clinical manager interviewed stated that there were no examples of residents being declined to the service. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's

		placement can be terminated. An example was provided of a resident admitted in November 2017. The facility was provided with a current interRAI assessment and notification of level of care required, however the facility found the resident required another level of care once admitted and with support of the family, NASC and GP the resident was transferred to another facility.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, challenging behaviours and depression scale, to identify any deficits and to inform care planning when the resident is initially admitted to the facility. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of two trained interRAI assessors on site with the care home manager having administration access. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant meeting both the physical needs and health needs of the residents. Any change in care required is documented and verbally passed on to relevant staff in handover. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP

		interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs within the facility and while out in the community.
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 an activity co-ordinator who works 30 hours a week (Monday to Friday) and is supported with training provided by the organizations head office. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities co-ordinator updates staff each day at morning handover. Residents and families/whānau are involved in evaluating and improving the programme through alternative monthly residents' meetings which are facilitated by an advocate from the community, day to day ongoing discussions with residents and satisfaction surveys. Residents interviewed confirmed they find the programme interactive and are encouraged and supported to maintain connections within the community.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported 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, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated.

		Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the physiotherapist, hospice, and clinical nurse specialist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required Chemical Handling Approved Handler Training (HSNO). 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 staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	A current building warrant of fitness (expiry date 01 May 2018) is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews

		with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence is promoted. Hot water temperatures from one cylinder is regularly below the recommended temperature and this requires improvement. External areas are safely maintained and are appropriate to the resident groups and setting. Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. New Provider Interview January 2018: HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each facility. There are presently no plans for any environmental changes in the facility.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes shared ensuites and additional toilet/shower rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining	FA	Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.

needs.		
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site in a dedicated laundry staff, or by family members if requested. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents and family members interviewed reported the laundry is managed well and their clothes are returned in a timely manner. There is a small designated cleaning team who have received appropriate training. These staff have completed the relevant on-site and organisational cleaning programme. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 29 November 2005. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 21 Dec 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for thirty-eight residents. Water storage tanks are located around the complex. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden areas. Heating is provided by electric panel heaters in residents' rooms and a heat pump in the communal areas. Areas were at an appropriate temperature and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the organisation's operations manager who is a registered nurse and quality services improvement team. The infection control programme and manual are reviewed annually. The clinical manager is currently the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported at the monthly infection control meeting and staff meetings. This committee includes the home care manager, IPC coordinator, the health and safety officer, and representatives from food services and household management. Staff discourage visitors from visiting the facility when unwell and signs were also observed at the front entrance to 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.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator/clinical manager has appropriate skills, knowledge and qualifications for the role. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely

		treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing amenities, hand washing signs and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by 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 is evidence that additional staff education has been provided in response. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, upper and lower respiratory tract, and wound infections. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early

		intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility and clinical manager and the organisation. The facility is benchmarked externally with 65 other facilities within the organisation showing overall a low infection rate. The facility (not counting the three outbreaks) has had six residents identified with an infection since August 2017. Two of the six infections recorded were related to one resident who has a frequent infection due to a chronic illness and interventions are evidenced in short term care plans and the long-term care plan to reduce and minimise the risk of further infections. A summary report for a respiratory outbreak in June and October and a diarrhoea/vomiting outbreak in August 2017 was reviewed and demonstrated thorough processes for investigation and follow up and support from health professionals in the community. Learnings from the events have now been incorporated into practice, with additional staff education implemented.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice her role and responsibilities. On the day of audit, no residents were using restraints and no residents were using enablers. There have not been any restraints or enablers in use since the last audit, as confirmed in reviewing the restraint register. New Provider Interview January 2018: HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for use of enablers. These policies are implemented across the group and a small number of restraint devices are approved for use following assessment. The prospective provider is experienced in the requirements

		of the standard, as it pertains to aged residential care.

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 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	A complaints management system is in place, however not all complaints have been included on the complaints register, including a recent HDC complaint, until the day of the audit. The complaints register does not include actions taken or the date when the complaint was resolved. There is a ‘yes/no column to tick if a complaint is substantiated. The actions or follow-up are included on a separate complaints form, but again there is no clear date on when the complaint has been resolved to the satisfaction of the complainant.	The complaints register is not current and does not include dates and actions taken.	An up-to-date complaints register is maintained and includes dates and actions taken. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	Hot water temperatures are checked monthly and documented. A review of recordings for one hot water cylinder serving the sluice room, kitchen and staff sink showed that between September 2017 and February 2018 only three recordings of eighteen were above the recommended 65 degrees celsius. The maintenance person did not report this to the CHM or document it on a corrective action form. During interview he	One hot water cylinder is not always reaching the recommended temperature.	All plant and equipment is to comply with legislation. 90 days

		thought it may have been during busy times but as he no longer writes the time of the recording this could not be verified. The hot water cylinder has no tempering valve.		

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.