

Heritage Lifecare (BPA) Limited - Telford Rest Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare (BPA) Limited
Premises audited:	Telford Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 June 2021 End date: 11 June 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	52

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
Yellow	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
Red	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

Heritage Lifecare (BPA) Limited own and operate Telford Rest Home & Hospital in New Plymouth. The facility can take up to 53 residents, 28 dual purpose beds and 24 registered hospital level beds. The facility is managed by a facility manager and clinical manager with support from a regional manager and central office structure. The residents and family members spoken with were positive about the care and communications with managers and staff.

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

A strength of this organisation is their commitment to continuous improvement and seeking to improve the lifestyle of their residents. Two areas were identified during the audit as areas for improvement, these relate to the currency of Heritage Lifecare's policies and procedures and the review of the residents long term care plans.

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk management plans included the mission, vision and goals of Heritage Lifecare. A new 'Heritage Way' is being implemented into all processes around the services. Monitoring of the services provided to the governing body was 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.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Residents of Telford Lifecare have their needs assessed by the multidisciplinary team on admission and within the required timeframes. Handovers at the beginning and end of each shift and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being well informed and involved in care planning and evaluation. They expressed satisfaction with the care provided at Telford Lifecare.

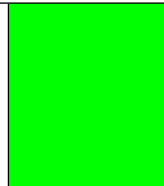
The planned activity programme is run by an activities co-ordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

There is a current building warrant of fitness and no changes to the building have occurred since the last audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The organisation has implemented Heritage Lifecare policies and procedures that support the minimisation of restraint and promotes safe use of and consented enabler use. Two residents were using restraints and two residents were using enablers during the audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Surveillance of aged care specific infections is undertaken at Telford Lifecare. Data is analysed, trended, and benchmarked. Results are 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	14	0	2	0	0	0
Criteria	0	37	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The Heritage complaints policy and associated form meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that five complaints have been received in 2020 and two to date, in 2021. A sample of four complaints over the past year were reviewed and showed that actions taken, through to resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The care home manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There has been one complaint received from the DHB in May 2020, which was responded to in a timely manner. Corrective actions were put in place and the DHB accepted and signed off in November 2020.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members interviewed stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. One incident and the 2019 resident and family survey indicated a communication issue being identified, with numbers being small. A corrective action process has been put in place with education for all staff. There has been no further issues raised and communication was evident in residents' records reviewed.</p> <p>Staff understood the principles of open disclosure, which is supported by Heritage Lifecare organisational wide</p>

<p>provide an environment conducive to effective communication.</p>		<p>policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although the facility manager reported they had never needed to access this service, as the majority of residents speak English. Staff reported one resident who has English as a second language and the patient has a good understanding of English if he is spoken to slowly. Staff are multicultural and spoke a range of languages, including Te Reo (Maori).</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 strategic and business plans, which are reviewed annually, outline the mission, values goals and direction of the organisation. The documents described annual and longer term goals and the associated operational plans. The regional operations manager stated that reporting occurs weekly via zoom, monthly reports, example sighted and she undertakes regular site visits. These are used to report up to senior management and the CEO. The monthly reports to the regional operations showed extensive information being drawn from electronic systems to allow for monitor performance including, financial performance, clinical indicators, emerging risks and issues.</p> <p>The service is managed by a care home manager who has many years' experience in the age care sector and has been in the role for almost three years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The care home manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending sector specific workshops and receives newsletters as well as attending Heritage Lifecare manager conferences.</p> <p>The service holds contract with Taranaki DHB, including for respite care, and day care (one under DHB contract and one privately paying person) and Accident Compensation Corporation (ACC) for one long term resident. Fifty two residents were receiving services under the contract; with 28 rest home residents and 24 hospital residents at the time of audit.</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</p>	<p>PA Low</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. The review last year has seen a new quality programme initiated this year and includes the management of incidents and complaints, audit calendar activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents that include medication errors, falls, weight loss, challenging behaviour, restraint and pressure injury.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality meeting. Due to the electronic nature of reporting Heritage national quality team have ready access to monitor and review data and this was confirmed by the regional manager and sighted online. Staff reported their involvement in quality and risk management activities through meetings and quality initiatives. Three quality improvement initiatives sighted, commenced in 2019, relate to improving the day to day living of residents. These are; Pamper Room, Distraction Equipment and Interaction with staff and residents. These</p>

<p>improvement principles.</p>		<p>have made a difference, however due to Covid and other issues in 2020 these have not been evaluated at the time of audit. Minutes show corrective actions being undertaken and there is a well-developed process to address issues identified. This was sighted related to a DHB compliant, satisfaction surveys and a coroner's enquiry. Resident and family satisfaction surveys are completed annually, however last year the electronic system failed to provide the reports and this years is being undertaken in a different format. The 2019 survey showed overall satisfaction with the service with the issue identified mentioned above.</p> <p>Heritage Lifecare develop and maintain all policies used within Telford. Review of a sample showed they cover all necessary aspects of the service and contractual requirements, appropriate referencing of relevant sources and include reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are currently under review and a number were seen as being overdue, this is an area for improvement.</p> <p>The regional manager and facility manager were able to describe the Heritage Lifecare processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. They were familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on the electronic care system, which generates an email to senior staff for review and corrective actions. There is also a sentinel events form which is completed by senior staff. A sample of incidents 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, including clinical indicators, analysed and reported via the electronic system to senior staff of Heritage Lifecare senior management.</p> <p>The care home manager and clinical manager described essential notification reporting requirements, including for pressure injuries. Two Section 31 reports were sighted for this year which included clear documentation and corrective actions taken recorded. One death is presently going through the coroner's process. Investigation related to this death showed the identification of a number of areas for improvement including education of staff and evidence of this occurring was sighted. Monitoring of improvements is occurring by the clinical manager.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>FA</p>	<p>Heritage Lifecare human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes, visa checking, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of seven staff records (two RN, kitchen assistant, four care givers) reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. All health professionals (RN, general practitioner, dietitian, podiatrist,</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>physiotherapist and pharmacists) had a current APC.</p> <p>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 showed documentation of completed orientation and annual performance review.</p> <p>An annual education plan is in place which includes areas of mandatory training. This is reviewed each year to ensure areas identified from incidents or audits are included. The clinical manager keeps a list of care staff who have completed or have commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There were sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. The number of interRAI competent nurses has risen in the last year from two, plus the clinical manager to five, plus the clinical manager. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The Heritage Lifecare Allocation of Staff/duty roster sets out the principles of rostering based on NASC levels and contract requirements. The clinical manager spoke of the constant work to ensure staffing meets the skill mix to provide safe service delivery, 24 hours a day, seven days a week (24/7). There has been a moderate staff turnover in the last year and recruitment to all levels is underway. Staff rosters show that shifts are being filled with staff working extra hours to assist in situations where staff were off sick.</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. The care home and clinical managers are on call 24/7. Staff reporting that good access to advice is available when needed including the GP who is on call 24/7.</p> <p>Care staff reported they were stretched at times and have developed strategies to manage the workload. Residents and family interviewed stated their needs were being met and raised no issues about staffing. Observations and review of two six-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 and there is 24/7 RN coverage in the hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</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 member (RN) 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</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. At night, the second checker is not an RN, however, is someone who is deemed competent to check medications. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>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 is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this can be managed in a safe manner if required.</p> <p>Medication errors are reported to the RN and CSM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Telford.</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 by a cook 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 on 15 January 2021. Recommendations made at that time have been implemented.</p> <p>An up-to-date food control plan is in place, and due to expire 30 October 2021. The verification audit of the food control plan by the New Plymouth District Council on 29 September 2020, identified one area of corrective action around training. This has been addressed.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen</p>

		<p>staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. There are two dining rooms at Telford. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</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>Except for that referred to in criterion 1.3.3.3, documentation, observations, and interviews verified the provision of care provided to residents was consistent with their needs, goals, and the plan of care. A review on site of a recent complaint from the Taranaki District Health Board (TDHB), found the investigation questioned the timeliness of an admission to the TDHB, in addition to post fall assessments. The CSM had implemented a comprehensive action plan to address the findings. A review of two recent incidents onsite, found the post fall assessments and documentation had now been carried out as per the processes requested because of the investigation. Neither of these incidents required admission to the TDHB. Observations and interviews verified 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 of a high standard. Care staff confirmed that care was provided as outlined in handover information rather than in documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</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 service.</p>	FA	<p>The activities programme at Telford is provided by an activities co-ordinator, five days a week.</p> <p>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 regularly and as part of the formal care plan review every six months.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included exercise sessions, Alpaca visits, pizza day, word games, baking, Thai Chi, visiting entertainers, quiz sessions, theme days, visits from the schools, a recent visit to a musical show and daily news updates. The activities programme is discussed at the bi-monthly residents' meetings and minutes evidence residents' input is sought. Residents and family members of residents, when interviewed confirmed they find the programme meets their needs.</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 on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Except for those files referred to in criterion 1.3.3.3, formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the care provided. Short-term care plans were 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 dressing was changed. Evidence is sighted of effectiveness in management strategies around wound management, with a number of wounds healing quickly. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 29 July 2021) was publicly displayed. This covered the building and emergency egress. The care home manager stated there has been no changes to the buildings since the last audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance of infections at Telford is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICN and CSM review all reported infections. 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 quality/staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Tables are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>A good supply of personal protective equipment is available. Telford has processes in place to manage the risks imposed by Covid-19. A Covid-19 management plan has been implemented by the quality team at the organisations</p>

		<p>support office, and training resources are provided on an ongoing basis.</p> <p>The Covid-19 vaccination rollout at Telford has not commenced at the time of audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical manager supports a restraint coordinator to provide support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, two residents were using enablers and two resident had a restraint in use, which were the least restrictive and used voluntarily at their request. Each resident who had agreed to the use of an enabler had an enabler assessment form and consent signed by the next of kin. These were seen as being used appropriately in the residents files reviewed, and from interviews with staff.</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 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	PA Low	<p>A sample of policies reviewed identified that they were over the three year review date. The head of quality and clinical, stated the Clinical Advisory Group had identified the need for policy review of the large number of policies operated by Heritage Lifecare and are presently undertaking a review of these and related documents. They are prioritising the work with key areas being looked at first such as medication management and falls risk. The number, being out of date is constantly changing as the review process is completed by the document owner and agreed. It was estimated that between 35 and 40 percent were not current in the quality area and others were out of date in finance and property. Examples sighted as being out of date were interpreter and language and privacy.</p>	<p>All policies are Heritage wide and reviewed and updating centrally. There are a number of policies which were identified as being over their review date. Plans are in place to prioritise and review policies.</p>	<p>Implement the action plan to ensure staff have access to current best practice and legislation requirements.</p> <p>180 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>Four of the seven care plans reviewed had not been updated in the last six months or as the residents needs change. This was only regarding documentation, as progress notes, observations, and interviews evidence the care being provided is as per the residents identified needs. Prior to audit, the clinical service manager (CSM) has identified this has occurred, and attributes this to being due to a high number of RNs over the last eight months leaving to go to work at Taranaki District Health Board. A corrective action plan is in place and being attended to. For this reason, the corrective action is rated as a low risk.</p>	<p>Four of the seven care plans reviewed have not been updated in the last six months or as residents needs change.</p>	<p>Provide evidence that care plans up updated as residents needs change and are reviewed at least every six months.</p> <p>180 days</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.