

Lansdowne Park Village Limited

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 Health and Disability Auditing New Zealand 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:	Lansdowne Park Village Limited	
Premises audited:	Lansdowne Park Village	
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 9 February 2015	End date: 10 February 2015
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:	51	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Lansdowne Park provides rest home and hospital level care for up to 79 residents. The manager has been in her current role over a year and has a health background with over 31 years of experience. The Nurse Team Leader assumes clinical leadership role and she has been recently appointed to this role. The Nurse Team Leader position had been vacant for three months following the resignation of the previous Nurse Team Leader.

This unannounced surveillance audit was conducted against a subset of relevant Health and Disability standards and contract with the District Health Board. The audit process included review of policies and procedures, review of residents and staff files, observations and interview with residents, families, staff and management.

Lansdowne Park has addressed two of the five shortfalls from the previous audit around advanced directives and short term care planning. Improvements continue to be required around annual review of infection trends, medication signing sheets and care plan interventions. This surveillance audit identified further improvements required in relation to implementation of the quality management system, staff performance appraisals, family notification, complaint management documentation, infection control surveillance, care plan evaluations, long term care planning and the medication management system.

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.		Some standards applicable to this service partially attained and of low risk.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------------------------

Full information is provided at entry to residents and family/representatives. Family are involved in the initial care planning and ongoing feedback is provided. Resident's progress notes show that regular contact is maintained with families however review of incident and accident forms revealed that family notification following an incident /accident was not always documented. There are appropriate systems in place to manage the complaints processes and a register is maintained. The required corrective action from the previous audit around advanced directives has been addressed.

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.
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------------------------

The policies and procedures including the quality system have been developed by an external consultant and on-going support is provided. There is a document control process in place for all policies. The key components of service delivery are linked to the quality system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. There is an internal audit programme which is not fully implemented. There is a meeting schedule but meetings have occurred irregularly in the last six months.

The facility manager provides an extensive monthly report to the board and this includes all data from the quality and risk management system. Incidents and accidents are recorded and a registered nurse assessment is undertaken at the time of incident ensuring appropriate intervention.

There is an annual staff training programme that is implemented. The annual staff training programme is based on policies and procedures. Records of staff attendance are maintained. Human resource management policies are implemented but not all staff performance appraisals are up to date. Staff are encouraged to study towards obtaining a national qualification in care of elderly. Staffing roster has 24 hour registered nurse. There are adequate numbers of caregiver on each shift. Residents and families and staff interview confirmed sufficient staff to provide support and care.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-----------------------------------------------------------------------------------------------------------------------------------

Admission procedures, assessments and care plans are carried out by registered nurses. Documentation timeframes have not all met. A range of assessment tools were completed in resident files on admission and completed at least six monthly. Pain assessments and wound assessments were not always completed.

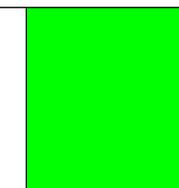
Residents' progress notes are up to date. Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. There is a house GP involved with the service that visits weekly or more frequently if needed.

Activities are planned and implemented by a diversional therapist and an activities assistant. Activities are provided appropriate for the residents and reflect ordinary pattern of life.

There are policies and procedures for all stages of medicine management and reflect legislative requirements. This audit identified several improvements required around implementation of the medicine management system including previous audit findings that remain have not been fully addressed.

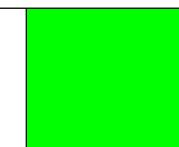
The kitchen provides meals for the care centre and the serviced apartments. Diets are modified as required. Resident and family interview confirmed that food services are often discussed with the management and gave examples of improvements that have been made.

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.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------	------------------------------------------------------

The building holds a current Warrant of Fitness which expires on 20 November 2015.

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 service aims to minimise the use of restraint in all forms and encourages the use of least restrictive practices. An extensive restraint practices review was completed in 2014 by the facility manager. This included review of all restraint and enabler practices ensuring that when restraint is used that it is practised in a safe manner.

Infection prevention and control

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

An individual resident infection form is completed and surveillance of infections is entered on to a monthly infection summary. Infections are discussed at all meetings. Previously identified shortfall around trend analysis of infection rates continues to require addressing. An improvement continues to be required around the annual review of Infection Control (IC) surveillance.

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	9	0	6	3	0	0
Criteria	0	29	0	7	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Lansdowne Park has well developed policies and procedures that support the provision of services, and complies with the Code of Health and Disability Rights. Information on informed consent is available at reception and is included in the information pack. All six files reviewed had appropriate consent forms and advanced directives that were signed by the residents or not signed if the residents were assessed not competent by the GP. This is an improvement since the previous audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>There is a complaints register that includes evidence of follow up, investigation, and action taken. Complaint resolution was not clearly documented. Complaint forms are available in the home and can be accessed by residents, family members and visitors.</p> <p>Discussions with residents and family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. They also commented that communication has improved in recent months and they felt comfortable bringing up issues to the management team.</p>

		Meeting minutes reviewed included discussions around the complaints and staff interview confirmed this. Staff were able to discuss how they would assist residents or relatives who wished to voice or place a complaint. Four complaints were traced. All linked to the quality management system. There were several service improvements made following this process.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>Policies give guidelines on the requirements for contacting of families. Full information is provided at entry to residents and family or representatives. Families are involved in the initial care planning and on-going feedback is provided. Resident's progress notes identify that regular contact is maintained with family; however review of incident and accident forms revealed that family notification following an incident /accident is not documented.</p> <p>D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.</p> <p>D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b: Families interviewed confirmed they felt fully informed.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents.</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>	FA	<p>Lansdowne Park can provide rest home and hospital level care for up to 79 residents which include 29 residents in the services apartments. On the day of audit there were 51 residents (21 rest home residents and 12 rest home level care residents in serviced apartments and 18 hospital level care residents).</p> <p>The manager has been in her current role for over a year. The manager has over 20 years of experience in health management. The Nurse Team Leader assumes clinical leadership role and she has recently obtained this role.</p> <p>The policies and procedures align with current good practice. There is a business and quality plan.</p> <p>Interview with the facility manager confirms regular contact and monthly meetings with Directors.</p> <p>ARC, D17.3di (rest home, hospital), The Nurse Team Leader and the manager</p>

		<p>have maintained more than eight hours annually of professional development activities related to managing the service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The policies and procedures including the quality system have been developed by an external consultant and the facility manager confirms on-going support from this consultant. There is a document control process in place for all policies. Annual review of IC trends and staff training by the external consultant is scheduled to take place in February 2015.</p> <p>There is an internal audit programme. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the staff, however the audit schedule has not been fully implemented including follow up of some corrective actions.</p> <p>The Facility Manager provides an extensive monthly report to the directors and this includes all data from the quality and risk management system. The report also includes recommendations and implementation of corrective actions as required. Staff interviewed report they are kept well informed of quality and risk management issues including complaints, incident and accidents and clinical issues.</p> <p>The key components of service delivery are linked to the quality system.</p> <p>D19.3 There are risk management, and health and safety policies and procedures in place including accident and hazard management.</p> <p>D19.2g Falls prevention strategies are used such as (but not limited to) sensor mats, increased supervision, mobility assessments and environmental assessments.</p> <p>A resident and family survey was last completed in December 2014 and full analysis of the survey has not yet been completed. Meeting minutes identify that preliminary results were discussed with the RNs. For example, improvements are planned around improving family participation around six monthly medical reviews.</p> <p>Preventative maintenance occurs. There is a risk management register and hazards documented. A review of the hazard register indicates that these are signed off when resolved.</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>D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities. Incidents and accidents are recorded on a prescribed form and an RN assessment is undertaken at the time of incident ensuring appropriate intervention. Incidents are then forwarded to the management for trending and analysis. Meeting minutes showed that data is discussed at the monthly quality meetings and outcomes are reported to the directors and to staff. Five caregivers and three RNs interviewed were aware of the reporting process.</p> <p>Ten incident and accident forms were reviewed across the service and all demonstrated clinical follow-up by a registered nurse.</p> <p>Discussions with the Facility Manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no serious incidents or investigations.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There is a human resource management system in place. Eight staff files reviewed showed that there were various job descriptions relevant to roles and individual employment agreements signed as part of the recruitment process. Professional qualifications are verified at the time of employment and a monitoring record is kept. There is an orientation programme that is being implemented and includes a period of being buddied with senior caregivers. Five caregivers interviewed were able to describe the orientation process.</p> <p>Staff are encouraged to study towards obtaining a national qualification in care of elderly. The service employs 34 caregivers and 18 of those had gained their qualification. The service appointed a training facilitator to assist staff to complete their national qualification. There is an annual education program and staff are encouraged to take external training opportunities. Document review showed that training offered by the local DHB is advertised with memos and the staff letters.</p> <p>There is 24 hour RN cover and RNs can access internal and external training. An improvement is required around performance appraisals.</p> <p>D17.7d: There are implemented competencies for all registered nurses around medication and evidence in a registered nurse file that these have been completed.</p> <p>All residents and family members interviewed highly praised the all staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes for</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>safe service delivery.</p> <p>There are 60 staff including the Nurse Team leader, the Facility Manager, 34 caregivers and eight RNs. There are separate laundry, cleaning staff and kitchen staff. There are also other auxiliary staff that support the team.</p> <p>Staffing roster has 24 hour RN coverage. There are adequate numbers of caregivers on each shift. Residents and families interviewed stated that there was sufficient staff to provide support and care. Staff interview also confirmed adequate cover. Visual observations during this audit confirmed adequate staff cover provided.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Seventeen medication charts were sampled (seven for rest home residents, eight from hospital residents and two from serviced apartments –rest home level care). The facility utilises individual medication blister packs that are delivered monthly. Medication is checked on delivery and stored safely. Medication is kept locked when staff are not attending.</p> <p>The registered nurses and medicine competent caregivers administer medicines. Medication charts have photo identification and allergies and sensitivities are documented. There are policies and procedures around resident who self-administers medicines.</p> <p>Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Reconciliation of medication was evidenced as completed in the files reviewed. This audit identified several improvements required around implementation of the medicine management system including the previous audit finding that remains open.</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 kitchen is located on the ground floor and caters for the care centre and the serviced apartments. Meals are transferred via trolleys then placed in warmed Bain Marie. Caregivers serve the food from bain marie in kitchen area for apartment residents. The main meal is served in the evening. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly.</p> <p>Resident's dietary needs are identified on admission and these are communicated to the kitchen. Residents' likes and dislikes and special dietary requirements are noted in the kitchen and known by the staff. Kitchen staff interview confirmed this.</p>

		<p>Resident and family interview confirmed that food services are often discussed with the management, and gave examples of improvements that have been made. One resident interviewed stated that food services require more improvements. The other residents interviewed were happy with the food services and acknowledged that the management has been very responsive to their inquiries. On interview the chef stated that he monitors food satisfaction and several changes have been made to the menu to accommodate resident's likes and dislikes. The current menu is under review by a registered dietitian. Caregivers were observed serving and assisting those residents who required assistance with meals.</p> <p>Residents weights are monitored and nutritional supplements are available for residents as needed.</p> <p>Special equipment is available as needed. Additional snacks are available for residents when the kitchen is closed such as sandwiches, biscuits, bread and fillings. Residents are offered fluids throughout the day.</p> <p>D19.2 Staff have been trained in safe food handling</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Eight care plans reviewed identified that several parts of the care plan templates were not fully completed, and interventions required were lacked detail. These shortfalls were identified in the previous audit and remain an area for improvement.</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>	<p>PA Moderate</p>	<p>Residents' care plans are completed by the RN in conjunction with input from caregivers, the GP, residents and family members. The care plans reviewed were not up to date and did not include all aspect of the care. (link CAR 1.3.5.2 and 1.3.8.2).</p> <p>D18.3 and 4 Dressing supplies are available and a stock of supply is available. On the day of audit, there were 15 wounds which include skin tears, leg ulcers and two pressure sores.</p> <p>Continance products are available and resident files include a urinary continence assessment and bowel management. Continance products are identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.</p> <p>Five residents and three family members were interviewed and they were all complimentary of the care provided at Lansdowne Park. Staff were considerate of</p>

		<p>residents' needs as observed by the auditor on both days of audit.</p> <p>The RNs interviewed described the referral process and related form for referral to a wound specialist or continence nurse. On the second day of audit, one of the RNs had a phone consultation with a clinical nurse specialist regarding a complex wound and then arranged an onsite visit for full review of the wound. The RN team is skilled and experienced however there has been a lack of clinical leadership over four months (link 1.2.1) where it was noted that documentation was lacking.</p> <p>There is an improvement required around wound care assessments and referrals to other health services.</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>There is a diversional therapist (DT) who works 35 hours a week Monday to Friday. She is supported by activities assistant who works 20 hours a week. The DT attends a monthly DT support group. The activities programme is planned monthly and advertised in the resident's rooms and several notice boards in the facility. Daily prompts of activities that are occurring are also announced over the intercom system.</p> <p>Resident's interests, hobbies and past experiences are identified on admission and these are used to developed individual activities plan. Activities are provided appropriate for the residents and reflect ordinary pattern of life.</p> <p>Community connections are maintained and outings are provided. Resident and family interview confirmed this occurs.</p> <p>The activities coordinator described 1:1 interactions and time spent with residents who are unable or prefer not to join in group activities'.</p> <p>Resident meetings were occurred two monthly and follow up corrective actions were completed by the facility manager.</p> <p>Residents interviewed stated satisfaction with activities provided. .</p> <p>D16.5d Resident files reviewed (eight) identified that the individual activity plan is reviewed when at care plan review.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>D16.4a: Care plan evaluations are scheduled six monthly or more frequently when clinically indicated. This was evident in five out of eight files reviewed ((link 1.3.3.3). Evaluations are conducted by the RN with input from other RNs and the resident's GP, caregivers and the families. Residents and family are involved in</p>

		<p>reviewing care, and family interview confirmed this.</p> <p>On-going nursing evaluations occur as required and are included in the progress notes.</p> <p>Residents file review (five rest home, three hospital) showed that short term care planning was used for chest infections and urinary infections, and management of wounds. Short term care plans were reviewed and signed off when the issue had been resolved or transferred into the long term care plan. This is an improvement since the previous audit.</p> <p>The GP interview confirmed appropriate and timely referrals from the RNs.</p> <p>D16.3c: Initial care plans are evaluated by the RN within three weeks of admission (Link CAR.1.3.3.3).</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>	FA	<p>The building holds a current Warrant of Fitness which expires 20 November 2015 and maintenance is completed.</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>	PA Low	<p>IC surveillance is conducted monthly by the IC Nurse. An individual resident infection form is completed and surveillance of infections is entered on to a monthly infection summary. Infections are discussed at quality committee meetings, health and safety meetings and other staff and management meetings. Meeting minutes were viewed and confirmed there is consideration to new infection control issues. Follow up education relevant to specific issues is carried out. Staff interview confirmed this.</p> <p>Trend analysis of infection rates for the facility has not been completed. This is a previously identified shortfall that continues to require addressing. IC programme currently includes identifying antibiotic usage only; therefore not all infections are included in the surveillance programme.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is</p>	FA	<p>Restraint policy includes a definition of an enabler that is congruent with the definition in Standard 8141:2008. The policy outlines the process for enabler use; ensuring enablers are used with the intention of promoting and maintaining resident</p>

actively minimised.		<p>independence and safety by using the least restrictive option.</p> <p>Lansdowne Park aims to minimise the use of restraint in all forms and encourages the use of least restrictive practices. An extensive restraint practices review was completed in 2014 by the Facility Manager. This included review of all restraint and enabler practices ensuring that when restraint is used that it is practised in a safe and respectful manner. Staff received training around this and meeting minutes reviewed included broad discussions around that. Staff interviewed confirmed that this occurred. Restraint audits were completed and monitoring of restraint usage was enhanced.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	The complaints register is maintained that includes all complaints, dates, and actions taken.	Four complaints were traced. In all four cases, complaints were noted as resolved but there was no documented evidence that the complainant was satisfied with the outcome.	<p>Ensure that feedback is obtained or sought from the complainant regarding resolution of the complaint.</p> <p>180 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Open Disclosure policies guide staff in maintaining open, transparent communication with residents and families. Staff, family and resident interviews confirmed this.	In six out of 10 incident/accident forms reviewed, family notification had not been documented.	<p>Ensure accident/incident forms reflect that family are informed.</p> <p>90 days</p>
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system</p>	PA Low	There is a meeting schedule that includes a monthly quality committee, infection control meetings and health and safety	Quality committee / infection control meetings are scheduled monthly but have occurred irregularly since August 2014. The	<p>Ensure that meetings take place as scheduled and meeting minutes are available for staff.</p>

which is understood and implemented by service providers.		meetings. Resident meetings are scheduled four times a year. There is a set agenda in the quality committee and infection control meetings ensuring that all aspects of the quality and risk programme are discussed. Minutes sighted indicate that meetings were not always held as per schedule.	quality committee has not met since November. Health and safety meetings have been held irregularly and meetings minutes have not always been available to staff.	180 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	There is a meeting schedule and audit schedule in place. Internal audits for 2014 reviewed. Audit outcomes are communicated to staff and in some instances a memo has been issued for staff to create awareness.	Audit schedules in 2014 were not fully implemented. Corrective actions plans have been developed following completion of internal audits; however documentation does not reflect implementation. Meeting minutes reviewed showed that follow up or actions required from one meeting to another have not always been documented as completed.	<p>(i) Ensure that audit schedule is implemented. (ii) Ensure that corrective actions plans are implemented following completion of internal audits when a deficit is identified. (iii) Ensure that issues identified in the meeting minutes are documented as followed up.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	Human resources policies include recruitment, selection, orientation and staff training and development. Staff files reviewed indicated that robust employment processes were instituted.	Five of eight staff files reviewed did not have current performance appraisals.	<p>Ensure that staff performance appraisals are completed at least annually.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to</p>	PA Moderate	There are policies and procedures that include safe medicine management system, however noted documentation	(i) Controlled drugs reconciliation has not been conducted six monthly. (ii) Not all standing medication orders had the purpose	(i) Ensure that reconciliation of controlled drugs occur at least six monthly.(ii) Ensure that medication standing orders include purpose of

manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		shortfalls were identified.	of use documented by the GP. (iii) There was several signing gaps in all three areas of the service including serviced apartments and no documented rationale for medication not signed for/ not given was documented in progress notes or on the medication signing sheets. This was a partial attainment from the previous audit that continues to require addressing. (iv) Medication error reporting has not been completed for signing gaps in the medication signing sheet. (v) Six expired medications were noted in the rest home /hospital medication room. (vi) In five medication charts, three monthly medication reviews were not signed by the GP.	use documented by the GP. (iii) Ensure medications are signed for at time of administration and rationale for medication not signed for/not given is documented. (iv) Ensure medication error reporting is completed for medication that is not signed as given. (v) Ensure that expired medications are returned to the pharmacy. (vi) Ensure that three monthly medication reviews are signed by the GP. 60 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	The registered nurses and medicine competent caregivers administer medicines. Not all caregivers have up to date competencies.	There are eight medication competent caregivers and six of them did not have current competency assessments.	Ensure that all staff who administer medication have current competency assessments 90 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	There are three residents who administer their medication. Competency assessments of self-medication have been completed.	Self-medication monitoring has not been documented. One resident had multiple medications and some of these medications are given by staff. The resident had a private GP and uses a different pharmacy than the contracted pharmacy. Staff were unable to confirm the	Ensure that self-administration of medications by residents is clearly documented and monitored. 30 days

			resident's current medication list.	
<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>	PA Low	<p>Eight files were sampled from the hospital (3), rest home (3) and the serviced apartments (2). The initial assessment occurred on the day of admission and the initial care plan was developed at this point. Assessments were completed over the next 21 days. This was evidenced in all files reviewed. In three weeks of admission the long term care plans were developed. This has occurred in seven out of eight files reviewed. In five files, care plan evaluations were completed at least six monthly. All files sampled showed evidence of three monthly GP reviews.</p>	<p>(i) One hospital level care file reviewed showed that the long term care plan was completed six weeks after admission. (ii) One rest home resident from the studio apartment did not have completed a care plan evaluation completed for nine months. (iii) Two rest home residents had no care plan evaluation within six months. (iv) In tracer file, care plan evaluations did not include review of incident and accident reports. (v) In one hospital file, the care plan evaluation was incomplete in some part of the care plans. (vi) In one rest home file (serviced apartment), care plan evaluations were not completed since March 2014.</p>	<p>Ensure that service delivery timeframes are met and evaluations are fully completed.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>Eight files reviewed showed that two out of eight files had current care plan interventions and these were described the support required by the staff.</p>	<p>(i) Care plan interventions did not all include support required. For example, one resident requiring INR level monitoring did not have this included in the care plan. Another resident requiring CD medication did not have pain management interventions in the care plan and pain assessments were not completed ensuring that current treatment plan is successful. (iii) Two residents with wandering episodes did not have</p>	<p>Ensure that interventions are comprehensive and includes current level of care requirements.</p> <p>60 days</p>

			clear interventions in the care plan to guide staff in management of these episodes.	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Resident, family and GP interview confirmed that residents receive appropriate care.</p>	<p>(i) The wound register included 15 wounds (skin tears, leg ulcers and two pressure ulcers). Review of two complex wounds revealed that the wound assessment form was not fully completed, and wound condition was not recorded. In some instances, next due date for change of dressing was not documented. Initial wound assessment was not signed and dated, and the form was not fully completed. One of these residents required pain relief prior change of dressing (as required) but the pain status in the form was not completed. (ii) One resident with behaviours that challenge including wandering did not have a referral made for reassessment.</p>	<p>(i) Ensure that wound assessment and care plans are fully completed; (ii) Ensure that timely referrals for re-assessments are obtained.</p> <p>60 days</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>PA Low</p>	<p>Monthly infection data is collected and these are entered on to a monthly infection summary. Infections are discussed at the staff / health and safety, quality committee and other relevant meetings.</p>	<p>(i) IC surveillance programme only includes infections with antibiotic usage. (ii) Overall trend analysis of infection rates for the facility has not been completed. This is a previously identified shortfall that continues to require addressing.</p>	<p>(i) Ensure that infection surveillance includes all infections. (ii) Ensure that trending and analysis of infections is fully completed.</p> <p>90 days</p>

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.