# Waikanae Country Lodge Limited - Waikanae Country Lodge

## Introduction

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

The audit has been conducted by 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Waikanae Country Lodge Limited

**Premises audited:** Waikanae Country Lodge

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 1 August 2016 End date: 2 August 2016

**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:** 58

# 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 |
|  | 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

Waikanae Country Lodge provides hospital and rest home level care for up to 79 residents and on the day of the audit there were 58 residents. The service is overseen by an experienced village manager who has been in the role since December 2013. The village manager is supported by a clinical services manager who is well qualified and experienced for the role. Waikanae Country Lodge is supported by the Arvida General Manager Operations and the General Manager Wellness and Care. Residents and the families interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, staff and management.   
This audit has identified an improvement required around monitoring and interventions.

The service is commended for achieving two continued improvement ratings around falls prevention and infection surveillance.

## 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. |

Staff at Waikanae Country Lodge strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights (the Code). Residents’ cultural needs are met. Policies are implemented to support residents’ rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained,

## 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. |  | Standards applicable to this service fully attained. |

The quality and risk management programme includes service philosophy, goals and a quality/business planner. Meetings are held to discuss quality and risk management processes. Residents/family meetings are held regularly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. Falls prevention strategies are in place that includes the analysis of falls incidents. A comprehensive education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The village manager takes primary responsibility for managing entry to the service with assistance from the clinical services manager. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including InterRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the InterRAI outcomes and other assessments. They are clearly written and caregivers report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## 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 has a current warrant of fitness and emergency evacuation plan. On-going maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and some have individual bathrooms or shared ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounges and two dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and laundry staff are providing appropriate services. There is a planned and reactive maintenance programme in place. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

## 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. |

Waikanae Country Lodge has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. During the audit, ten residents were using restraints and one resident was using an enabler. A registered nurse is the designated restraint coordinator.

## Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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 | 49 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 2 | 98 | 0 | 0 | 1 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (six caregivers, four registered nurses, one diversional therapist, one cook, one second cook, one kitchen hand, one laundry person and one cleaner) confirm their familiarity with the Code. Interviews with eight residents (five rest home and three hospital) and three families (one rest home and two hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings. |
| 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 | Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Eight resident files sampled (three rest home – including one resident in the serviced apartments, and five hospital) demonstrated that advanced directives are signed for separately. The service is transitioning to the Arvida organisational documents and the Arvida advanced directive forms were completed on the day of audit for the resident files sampled.  The consents, evidence discussion with family, when the GP has completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative’s lives. All eight resident files sampled had a signed admission agreement signed on or before the day of admission and consents. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate. |
| 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 encouraged to be involved in community activities and maintain family and friends’ networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. There is a complaints register. Verbal and written complaints are documented. Six complaints have been made in the past 12 months. All complaints reviewed had noted investigation, timeframes and corrective actions when and where required, and resolutions were in place. Results are fed back to complainants. All staff interviewed were able to describe the process around reporting complaints. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the village manager discusses the information pack with the resident and the family/whānau. The information pack incudes a copy of the Code. |
| 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 | The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident’s privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met. A policy describes spiritual care. Church services are conducted regularly. All residents interviewed indicated that resident’s spiritual needs are being met when required. |
| 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 service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. On the day of the audit, no residents identified as Māori. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process. Discussions with staff confirm that they are aware of the need to respond to cultural differences. |
| 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 | The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident’s cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural safety/awareness. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incident/accidents forms reviewed had documented evidence of family notification or noted if family did not wish to be informed.  Relatives interviewed confirmed that they are notified of any changes in their family member’s health status. A residents/relatives meeting occurs and issues arising from the meeting are communicated to staff. The village manager investigates any issues raised from these meetings and there was evidence of implemented corrective actions. Interpreter services are available as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Waikanae Country Lodge is owned and operated by the Arvida Group. The service provides care for up to 79 residents with 59 dual-purpose beds (rest home/hospital) and up to 20 serviced apartments certified to provide rest home level care. On the day of the audit, there were 58 residents. There were 18 residents at rest home level and 39 residents at hospital level care. There was one rest home resident in the serviced apartments. All residents were admitted under the aged related residential care contact (ARRC).  The village manager has been in the role since December 2013 and she is an experienced manager with five years’ experience in similar positions in NZ. She is supported by a clinical manager who has been in the position for 20 years at Waikanae Country Lodge.  The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan and Waikanae Country Lodge has a facility quality improvement and risk management action plan in place for the current year. The organisation has a philosophy of care, which includes a mission statement. Waikanae Country Lodge is currently transitioning to the Arvida Group quality management systems and Arvida policies and procedures. The village manager has completed in excess of eight hours of professional development in the past 12 months. |
| 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 | In the absence of the village manager, the clinical manager is in charge. The general manager operations, the general manager wellness and care, and the care staff also provide support. |
| 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 | There is a business/strategic plan that includes quality goals and risk management plans for Waikanae Country Lodge. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager advised that she is responsible for providing oversight of the quality programme on site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. The site-specific service's policies are being transitioned over to the Arvida Group polices, which will be reviewed at least every 2 years across the group. The Arvida Support office maintains the relevance of, and updates all policy documentation on a regular basis. Waikanae Country Lodge has implemented the Arvida Group InterRAI assessment policy. Staff have access to manuals. Resident/relative meetings are held regularly.  Data is collected in relation to a variety of quality activities. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system that is regularly reviewed. Restraint and enabler use (when used) is reported within the quality and clinical staff meetings. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.  The internal audit programme continues to be implemented and all issues identified had corrective action plans and resolutions. All staff interviewed could describe the quality programme corrective action process. There is an annual staff training programme that is implemented and based around policies and procedures and records of staff attendances maintained. Infection control programme is implemented and all infections are documented monthly. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The 2015 resident relative survey overall result shows satisfaction with services provided. |
| 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 | There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents. Fourteen incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were not always documented for unwitnessed falls (link 1.3.6.1). Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| 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 | There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Eight staff files were reviewed (one clinical manager, three registered nurses, two caregivers, one diversional therapist and one kitchen manager) and there is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. Completed orientation is on files and staff described the orientation programme.  The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2015 has been completed and the plan for 2016 is being implemented. The village manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Waikanae Country Lodge policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has 60 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. In addition to the village manager and clinical manager who both work full time, there is at least one registered nurse and two caregivers on at any one time. The registered nurse on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirm there are sufficient staff to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregiver or registered nurse. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The village manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the village manager and clinical services manager. The admission agreement form in use aligns with the requirements of the ARRC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential aged care envelope (yellow) that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur. |
| 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 | Sixteen medication charts were reviewed (ten hospital, and six rest home). The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Residents’ medicines are stored securely in the medication room/cupboard. Medication administration practice complies with the medication management policy for the medication round sighted. Medication prescribed is signed as administered on the pharmacy generated signing chart. Registered nurses administer medicines. Caregivers complete a second checker medication competency, but do not administer medication. All staff that administer medicines are competent and have received medication management training. The facility uses a blister packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts correctly and there was evidence of three monthly reviews by the GP. Five rest home residents self-administer their own medicines (inhalers). The self-administration documentation was correctly recorded and a competency assessment completed. |
| 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 | There is a fully functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission, and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cook follow a rotating seasonal menu, which has been reviewed in December 2014 by an external dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. |
| 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 | The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is given. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six monthly, or when there was a change to a resident’s health condition. The InterRAI assessment tool is being implemented. InterRAI assessments have been completed for all residents. Care plans sampled were developed on the basis of these assessments (link 1.3.6.1). Nine of nine registered nurses are InterRAI trained. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed were overall individualised and consumer focused. The InterRAI assessment process informs the development of the resident’s care plan. The long-term care plans did not always describe the support required to meet the resident’s goals and needs as identified through the assessment process (link 1.3.6.1). Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Registered nurses (RNs) and caregivers, follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse [hospice nurse] or the mental health nurses). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.  Wound assessment, monitoring and wound management plans are in place for residents with wounds. Fourteen wound care plans were reviewed. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.  Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Care plan interventions did not always document interventions to meet residents’ assessed needs. Interventions in use were not fully documented. There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. Not all monitoring charts evidenced the required monitoring was completed  The service has commenced a project around falls preventions for residents with results showing improved outcomes for residents (link 1.2.3.6). The service has also implemented a project in May 2016 around pressure injury prevention, which is showing an increase in the use of pressure injury preventative measures. |
| 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 | One diversional therapist and one activities coordinator are currently operating the activities programme for all residents. The service is currently recruiting to fill the vacant diversional therapy position. The programme is supported by nine volunteers. The programme operates seven days a week. Each resident has an individual activities assessment on admission, which is incorporated into the InterRAI assessment process. An individual activities plan is developed for each resident by the diversional therapist in consultation with the registered nurses. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All long-term resident files sampled have a weekly activities plan, which is appraised monthly by the diversional therapist. The diversional therapist also reviews the social profile and the recreational plan three monthly, when the care plan is evaluated and if a further InterRAI assessment occurs. Residents interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that long-term care plans were evaluated at least six monthly or earlier if there was a change in health status. There was at least a three monthly review by the GP. All changes in health status were documented and followed up. Reassessments have been completed using InterRAI LTCF for all residents who have had a significant change in health status. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| 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 | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident’s condition had changed and the resident reassessed. |
| 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 | There are implemented policies in place to guide staff in waste management. The service has implemented a programme to compost the facility’s organic waste on site. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 30 November 2016. The service is actively recruiting to fill the maintenance position due to the recent resignation from this position. The village manager is overseeing the reactive and planned maintenance programme until this position is filled. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| 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 an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have shared ensuites and other residents share communal toilets and showers. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| 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 | All resident’s rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their 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 needs. | FA | The communal areas include a large lounge and dining area and several smaller lounges and two dining areas. These are large enough to cater for activities. |
| 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 | There are dedicated cleaning staff rostered on seven days per week. They have access to a range of chemicals, cleaning equipment and protective clothing. A recent quality improvement has resulted in a flip chart being developed and available to all cleaning staff to visually guide them on the cleaning requirements of each area. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.  There are dedicated laundry staff rostered on seven days per week. The laundry has recently been refurbished. All laundry is completed on-site in an appropriately appointed laundry. Residents interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place.  A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.  There are call bells in the residents’ rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. |
| 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 | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight. |
| 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 | Waikanae Country Lodge has transitioned to the Arvida group infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support and supervision from the clinical services manager and other members of the infection control team. Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Arvida infection control programme is scheduled to be reviewed annually. |
| 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 | A registered nurse is the designated infection control (IC) coordinator. The infection control coordinator receives supervision and support from the clinical serves manager. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team have good external support from the Arvida Group support office and the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| 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 | Waikanae County Lodge has just transitioned to the Arvida group infection control policies and procedures. The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator attends the Arvida Group infection control training, and is provided with education and updates through this forum. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records. |
| 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 | Infection surveillance is an integral part of the infection control programme and is described in the Waikanae Country Lodge infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the village manager and head office staff. There have been no outbreaks since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There are 10 residents with 14 restraints (nine bedrails and five lap belts) and one resident using an enabler (bedrails) during the audit. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on restraint minimisation and management of challenging behaviour has been provided. Restraint has been discussed as part of quality meetings. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | A registered nurse is the designated restraint coordinator (interviewed). Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes assessments for residents who require restraint or enabler interventions. Five restraints and one enabler file was sampled. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Assessments identify the specific interventions or strategies trialled before implementing restraint. Approved restraints are documented. Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator. The use of restraint is linked to the residents’ care plans. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring charts were not consistently documented for five out of ten monitoring forms for residents on restraint (link 1.3.6.1). A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. The service has a restraint and enablers register that is updated each month. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | The registered nurse uses information gathered through the assessment process, discussions with the care staff and observations of the resident to identify the required interventions that will meet the assessed care needs of the resident. The interventions and any associated monitoring requirements are documented in the care plan. Not all interventions in use or interventions required were documented in the care plan. Not all monitoring requirements outlined in the care plan were evidenced. | i) Neurological observations were not documented, according to the frequency outlined in the organisational policy, for two residents (one hospital and one rest home) following unwitnessed falls.  ii) Monitoring charts were not consistently documented as required for one hospital resident (tracer) on a 2-4 hourly turning regime, and five of ten residents using restraint.  iii) Specific interventions were not documented for monitoring for signs of infection for one hospital resident with a supra pubic catheter with a previous history of urosepsis. The care plan was amended on the day of audit to include the specific interventions and monitoring required.  iv) Interventions in use were not documented in the care plan for one rest home resident with weight loss who was seen by the GP and commenced on Ensure and was using a sensor mat. The care plan was amended on the day of audit to include all interventions in use.  v) Interventions were not documented for one rest home resident with a history of migraine headaches, one hospital resident requiring assistance to turn in bed, and one hospital resident with weight loss. The care plans were amended on the day of audit to include specific interventions for the assessed care needs. | i) Ensure that neurological observations post an un-witnessed fall are completed as outlined in the organisational policy.  ii) Ensure that all required monitoring is completed and consistently documented.  iii) Ensure that interventions are documented in sufficient detail to guide care staff for all assessed care needs.  iv) Ensure that all interventions in use are documented in the care plan.  v) Ensure that interventions are documented for all care needs.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Robust systems are in place for the collection, analysis and evaluations of quality data. Results are communicated to staff via a variety of forums. A range of data is collected across the service. Data is collated and analysed with evaluation reports completed monthly, and comparative reports annually. Data analysis is enhanced using charts, which identifies normal variation, patterns and trends. Communication of results occurs across a range of meetings across the facility (eg, quality meetings, staff meetings, RN/clinical meetings). Templates for all meetings document action required, timeframe and the status of the actions. | Collated data is used to identify any areas that require improvement. The quality programme for 2016 includes objectives for improving outcomes for residents. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Falls in the rest home were identified as an area that required improvement from data collected from July 2015. A project, preventing falls through better teamwork, was developed as part of their 2016 quality goals. It included identifying residents at risk of falling, providing falls prevention training for staff, reviewing call bell response times, reviewing the roster to ensure adequate supervision of residents, routine checks of all residents specific to each resident’s needs (intentional rounding), the use of sensor mats and reviewing of clinical indicator data. The plan has been reviewed quarterly and discussed at quality and staff meetings. Education and training for staff has been regularly provided. Evaluation identified that there were 92 falls from 01 January to 31 June 2015 and 74 falls during the same period of 2016, resulting in a reduction of 18 falls in 2016 in comparison to 2015. |
| Criterion 3.5.7  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. | CI | In May 2016, the service implemented a number of initiatives as a result of infection surveillance data to reduce infection numbers. IC statistics are discussed at all meetings and corrective actions are implemented when infections increase. Staff have been provided with a questionnaire to assess their infection control knowledge. Education has been provided to staff where gaps have been identified. The quality indicator corrective action plan shows a number of implemented actions including (but not limited) toolbox talks, care and hygiene spot audits. The services benchmarking data shows the incidents of eye infections, soft tissues and respiratory infections have all reduced since the initiative was implemented. | In May, the service commenced a project to reduce the overall rate of infection through prophylactic measures. An infection control committee was formed representative of the site and they were tasked with improving the knowledge of prophylactic infection control practices. The team gave a number of toolbox talks around standard precautions, hand washing and mode of infection transmission. All staff were required to complete a questionnaire on infection control and where gaps were identified, one-on-one training was provided. There has been an overall reduction in the rates of infection from 23 in April to 17 in July. |

End of the report.