# Lansdowne Park Village Limited - Lansdowne Park Village

## 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:** Lansdowne Park Village Limited

**Premises audited:** Lansdowne Park Village

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

**Dates of audit:** Start date: 8 August 2016 End date: 9 August 2016

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 61

# 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

Lansdowne Park village is part of the Arvida aged care residential group. The rest home provides rest home and hospital level of care for up to 50 residents in the care centre and up to 29 residents at rest home level in the serviced apartments. On the day of the audit, there were 61 residents.

The residents and relatives spoke positively about the care and services supports provided at Lansdowne rest home and hospital.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

Areas for improvement identified at this audit related to corrective actions and documented quality data, education, documented risks of restraint use, care plans, interventions and medication reviews.

## 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 Lansdowne Park 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. Information on informed consent is included in the admission agreement and discussed with residents and relatives. 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. |  | Some standards applicable to this service partially attained and of low risk. |

The quality and risk management programme includes service philosophy, goals and a quality/business planner. Quality meetings are held to discuss quality and risk management processes. Residents/family meetings are held every three months 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. 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. |

There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals.

Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident files included medical notes by the contracted GP and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. Administration signing sheets corresponded with the prescribed medications.

A diversional therapist oversees the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for rest home and hospital residents.

Residents' food preferences and dietary requirements are identified at admission and all meals and baking is cooked on site. Special diets and dislikes are accommodated. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident rooms are personalised with ensuites. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk. |

Lansdowne Park Village 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, four residents were using six restraints and two residents were 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. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinators use the information obtained through surveillance to determine infection control activities and education needs within the facility. There have been no outbreaks.

## 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 | 44 | 0 | 4 | 2 | 0 | 0 |
| **Criteria** | 0 | 94 | 0 | 5 | 2 | 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 DeliveryConsumers 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 (eight caregivers, three registered nurses, one diversional therapist) confirm their familiarity with the Code. Interviews with nine residents (five rest home and four hospital) and three families (two rest home and one hospital) confirm the services being provided are in line with the Code.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in eight of eight resident files reviewed (four rest home including one resident in a serviced apartment and four hospital including one resident under the health recovery contract). Advance directives if known, were on the resident files. Resuscitation plans for residents were signed appropriately. Copies of EPOA were present on resident files and activated as required. An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. All files evidenced signed general consents. All residents had signed admission agreements on file. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. 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 ResourcesConsumers 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 2016 (year to date) and 12 complaints made in 2015. 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 DeliveryConsumers 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 RespectConsumers 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 and they have choice. Church services are conducted monthly. All residents interviewed indicated that resident’s spiritual needs are being met when required. The caregivers can describe the process of identifying and reporting any abuse or neglect (link 1.2.7.5). |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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. There were no residents identified as Māori on the days of the audit. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. 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 BeliefsConsumers 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: DiscriminationConsumers 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 PracticeConsumers 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.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents/families 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 every three months and issues arising from the meeting are communicated to staff. Interpreter services are available as required.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lansdowne Park Village is owned and operated by the Arvida Group. The service provides care for up to 79 residents with 50 dual-purpose beds and up to 29 serviced apartments certified to provide rest home level care. On the day of the audit, there were 61 residents. There were 28 residents at rest home level and 18 residents at hospital level care (including two residents under the health recovery contract and one resident receiving palliative care). There were 15 rest home residents in the 29 serviced apartments. All other residents were admitted under the aged related care agreement (ARC).A village manager has been in the role since December 2013 and has 20 years’ experience in health management. A full time clinical manager supports the village manager. The clinical manager has been in the position for one month and has over 20 years aged care experience as an RN and facility manager. The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report. Arvida Group has an overall business/strategic plan and Lansdowne Park Village has a facility quality improvement and risk management action plan in place for the current year, 1 April 2016–31 March 2017. The organisation has a philosophy of care, which includes a mission statement. Lansdowne Park Village is currently transitioning to the Arvida Group quality management systems and Arvida policies and procedures (October 2016). 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. Support is also provided by the General Manager Operations, the General Manager Wellness and Care and the care staff.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There is a business/strategic plan that includes quality goals and risk management plans for Lansdowne Park Village. 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 policies (October 2016), which will be reviewed at least every 2 years across the group. Head office sends new/updated policies. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service collates accident/incident and infection control data. Monthly staff meeting minutes sighted did not evidence follow-up actions or staff discussion around quality data and accident/incident trend analysis. The service has a health and safety management system that is regularly reviewed. Restraint and enabler use (when used) is reported within the quality meeting. 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. 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. Resident/family meetings occur every three months and resident and families interviews confirmed this. |
| 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. Incidents are reported to meetings however, there is no documented evidence that analysis and resulting corrective actions are reported to meetings (link 1.2.3.6). A registered nurse conducts clinical follow-up of residents. Twelve incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 incident notification forms (sighted) completed in 2016.  |
| 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.  | PA Low | 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. Nine staff files were reviewed (one village manager, one clinical manager, two registered nurses, two caregivers, one diversional therapist, one senior cook and one laundry/cleaning person) and there is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme. The orientation programme covers different roles.The in-service education documentation for 2015 was not available for review on the day of audit. The in-service education plan for 2016 is being implemented. Four of the seven registered nurses have completed InterRAI training. There was education and training for clinical staff, which was provided by the local DHB. The clinical manager and the RNs attended external training around pressure injury prevention. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Lansdowne Park Village policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has 75 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.There were four rest home caregivers in the morning (two for the serviced apartments), three rest home caregivers in the afternoon (one for the serviced apartments) and one rest home/serviced apartments caregiver covering at night. |
| 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 | Residents’ entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs are provided for families and residents prior to admission. Families interviewed confirmed they had received sufficient information on admission and had the opportunity to discuss the admission agreement with management. All admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service. |
| 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. | PA Low | There are policies and procedures in place for safe medicine management that meet legislative requirements. Staff who administer medications (RNs and caregivers) have been assessed for medication and insulin administration competency. Registered nurses have completed syringe driver training. The pharmacist has provided education on medicine management. The RN checks all medications on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Standing orders are not used. There was a self-medication assessment and monitoring in place for one rest home resident self-medicating. All medications are stored correctly and eye drops dated on opening. The medication fridge is monitored weekly. Staff were observed to be safely administering medications at two rounds, one in the hospital and one in the rest home. Standing orders are not used. No residents are self-medicating. All 16 medication charts sampled met legislative prescribing requirements for regular medications, however not all ‘as required’ medications had an indication for use. The GP had not reviewed four of the medication charts three monthly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals and baking at Lansdowne are prepared and cooked on site by two qualified cooks who are supported by morning and afternoon kitchenhands. There is a five weekly menu, which had been reviewed by a dietitian. Meals are served from a bain-marie to residents who dine in the main dining room. Meals are plated and delivered by trolley to the kitchenettes in each wing. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements and food preferences are met. Special diets include dairy free, pureed/soft, high protein diets and thickened fluids. Staff were observed assisting residents with their meals and drinks in the hospital dining rooms. Fridge and freezer temperatures are taken and recorded daily. Temperatures for all facility fridges in kitchenettes are taken and recorded. End cooked food temperatures are recorded. All foods were dated. The dishwasher is checked regularly by the chemical supplier. A cleaning schedule is maintained. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. All food services staff have completed training in food safety and hygiene and chemical safety.  |
| 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 | There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RN completes an initial assessment on admission including relevant risk assessment tools. An InterRAI assessment is undertaken within 21 days of admission and six monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summary were in place for the seven long-term resident files reviewed. The long-term care plans in place reflected the outcome of the assessments however the supports/needs had not been documented in all files reviewed (link 1.3.5.2).  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Resident care plans reviewed were resident focused and individualised. The level of risk as identified in risk assessments was documented in the long-term care plan; however there were shortfalls around documented supports to meet the resident’s assessed needs. Residents and relatives interviewed stated they were kept informed of the relative’s health and outcomes of GP visit; however, there was no documented evidence of relative/resident involvement in the development of care plans. Short-term care plans document appropriate interventions to manage short-term changes in health.Resident files demonstrate service integration. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian and wound nurse specialist.  |
| 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 | When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative’s health. Discussions with families and notifications are documented on the next of kin contact sheet in the resident files reviewed. Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for seven wounds including two chronic wounds. There was one facility acquired stage-two pressure injury. There was evidence of GP and wound nurse involvement in review and management of chronic wounds and the pressure injury. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Monitoring charts are available but not always implemented when identified as required in care plans.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs a qualified diversional therapist (DT) who develops and implements the integrated activity programme with the support of an activity assistant. The activity programme is from Monday to Friday. Activities provided meet the recreational preferences of rest home and hospital residents. Activities occur in the lounges of each wing or in the large activities room. One-on-one time is spent with residents who are unable to or choose not to join in with group activities. There is a choice of activities to attend when both of the activity team are on duty. The activity programme is varied (but not limited to) walks, exercises, news reading, word games, baking, cards, Tai Chi, entertainers, weekly mystery drives and outings into the community. A volunteer assists with the activity programme. There are regular church services and residents are supported to attend their own church. A diversional therapy assessment and activity plan was in place for long-term residents. The activity plan is reviewed at the same time as the care plan. Residents have the opportunity to provide feedback directly and through surveys and resident meetings.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The RN evaluated all initial care plans (reviewed) within three weeks of admission. Long-term care plans have been reviewed at least six monthly or earlier for any health changes and evaluated against the resident goals. The GP reviews the residents three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.  |
| 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 | Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.  |
| 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 | Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored safely throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training.  |
| 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 20 November 2016. The service employs a full-time maintenance person. The maintenance officer ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained that includes resident equipment, communal equipment, internal and external building maintenance. Essential contractors are available 24 hours. The maintenance officer has been certified to conduct electrical testing which is completed two yearly. An external contractor completes annual calibration and functional checks of medical equipment. Hot water temperatures in resident areas are monitored and maintained below 45 degrees Celsius. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade is provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 | All resident rooms have ensuites. Communal toilets are located closely to communal areas. A large shower room can accommodate a shower trolley. Toilet and shower facilities are of an appropriate design to meet the needs of the residents. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant. |
| 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 rooms are single and personalised. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms. This was evident on the day of audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large communal lounge and smaller lounges in each wing for quieter activities and visitors. There is a large main dining area and smaller dining area within the wings. There is a large activity room. Seating and space in the main lounge is arranged to allow both individual and group activities to occur. All communal areas are easily accessible for residents to assist using mobility aids or with staff assistance.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry staff seven days a week. There are defined clean/dirty areas in the laundry with an entry and exit door. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal and external audits monitor the effectiveness of the cleaning and laundry processes. The cleaning trolleys are well equipped and stored safely when not in use.  |
| 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 with the last fire drill occurring on 20 May 2016. 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 backup 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 | Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The underfloor heating throughout the facility is centrally controlled.The residents and family interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The infection control coordinator (RN) has been in the role three years and oversees infection control for the facility. The infection control coordinator has a job description. Infection events are collated monthly and reported to the quality and infection control committee meetings.The 2015 infection control programme has been reviewed February 2016 and is linked to the quality system. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the influenza vaccine.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The RN infection control coordinator has attended infection control in-service at least annually, last at the DHB August 2015. The infection control committee is representative of all services and meet regularly to review infection control goals, complete infection control audits and review infection events. The infection control coordinator has access to GPs, nurse practitioner, local laboratory, DHB infection control nurse and wound nurse specialist, and public health departments at the local DHB for advice and support.  |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed by an external infection control specialist and are reviewed regularly.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed on orientation and are ongoing. Resident education is expected to occur as part of providing daily cares as appropriate. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at the quality, staff and infection control committee meetings. Annual infection control reports are provided. Monthly and annual trends are identified and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility. Organisational benchmarking is completed and fed back to the facility. There have been no outbreaks.  |
| Standard 2.1.1: Restraint minimisationServices 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 were four residents with six restraints (three bedrails and three lap belts) and two residents using an enabler (one bedrail and one lap belt) during the audit. 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 is being discussed as part of quality meetings.  |
| Standard 2.2.1: Restraint approval and processesServices 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. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. |
| Standard 2.2.2: AssessmentServices 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. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the three restraint and two enabler files sampled. 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 UseServices use restraint safely | PA Low | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. Assessments identify the specific interventions or strategies trialled before implementing restraint. 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. Interventions to manage the risks were not always documented in the care plan. 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: EvaluationServices 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. An assessment form/process is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that did not always reflect identified risk (link 2.2.3.4). The service has a restraint and enablers register that is updated each month. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The service has documented evaluation of restraint every three months. Evaluation timeframes are determined by policy and risk levels. 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 the quality meetings.  |

# 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 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service collates accident/incident and infection control data. Incident/accident data is available to all staff on the staff notice board monthly. However, monthly staff meeting minutes sighted did not evidence follow-up from the previous meetings or staff discussion around quality data and accident/incident trend analysis. | There is no evidence of quality data and incident/accident trends analysis being discussed at staff meetings. Meeting minutes reviewed showed that follow-up corrective actions have not always been documented as completed. | Ensure that quality data and incident/accident trends analysis is discussed at staff meetings. Ensure that any corrective actions follow-up from meetings are documented as completed90 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The in-service education documentation for 2015 was unable to be reviewed. Advised, that all of the hard copy documentation of the 2015 education plan was lost, when the previous manager left the organisation. The village manager could not locate it on the days of the audit. Significant work has been completed since January 2016 to ensure a comprehensive education programme & recording is in place to meet two yearly requirements. The in-service education plan for 2016 is being implemented. The CM and another RN are in the process of completing InterRAI. Staff complete competencies. | There was no documented evidence/records to reflect that two yearly education/training for the following mandatory education topics; abuse and neglect, complaints, open disclosure, nutrition/hydration, pain management, end of life, sexuality/intimacy, wound care and pressure injury prevention has been completed. Noting these are scheduled for 2016. | Ensure that education/training is provided on the mandatory education/training topics and records are maintained.90 days |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | Medication charts generated by the pharmacy are legible, dated and signed by the GP. ‘As required’ medication had indications for use on 11 medication charts. The GP had reviewed 12 of 16 medication charts at least three monthly.  | (1) There were no indications for use for ‘as required’ medication (codeine, morphine, tramadol, ibrufen, and loperamide) prescribed on five of 16 medication charts. (2) Four of 16 medication charts had not been documented as reviewed by the GP at least three monthly. | (1) Ensure all ‘as required’ medication have a prescribed indication for use. (2) Ensure medication charts are reviewed by the GP at least three monthly. 90 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Seven resident long-term care plans and one health recovery plan were reviewed. Not all care plans documented all interventions to meet the resident’s current health status or provided evidence of resident/relative involvement in the development of the care plans.  | (1) Three resident care plans (two hospital and one rest home) did not document appropriate pressure injury interventions to meet the assessed level of risk. (2) Three resident care plans (one hospital and two rest home) did not document appropriate falls prevention strategies to meet the assessed level of risk. (3) There was no diabetic management plan in place for one insulin dependent rest home resident.  | Ensure care plan interventions clearly include all supports to meet the resident’s current health status. 60 days |
| Criterion 1.3.5.3Service delivery plans demonstrate service integration. | PA Low | Residents and relatives interviewed stated they were kept informed of the relative’s health and outcomes of GP visit. However, there was no documented evidence of relative/resident involvement in the development of care plans or provided evidence of resident/relative involvement in the development of the care plans. Discussions with families and notifications are documented on the next of kin contact sheet in the resident files reviewed. | There was no documented evidence of resident/relative involvement in the development of care plans for two hospital and four rest home residents.  | Ensure there is documented evidence of resident/relative involvement in the development of care plans.90 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | There are a number of monitoring forms and charts available for use including (but not limited to) weight, vital signs, neurological observations, blood glucose, pain, behaviours, restraint, safety checks and challenging behaviour. Interventions had not been implemented for unwitnessed falls, identified pain, weight loss and changes in elimination.  | There were no interventions implemented for the following; a) two hospital residents with weight loss, b) one rest home resident with identified pain and elimination problems and c) there were no neurological observations for eight unwitnessed falls as per policy.  | Ensure monitoring charts are completed when identified, as required in care plans. 60 days |
| Criterion 2.2.3.4Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:(a) Details of the reasons for initiating the restraint, including the desired outcome;(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;(c) Details of any advocacy/support offered, provided or facilitated;(d) The outcome of the restraint;(e) Any injury to any person as a result of the use of restraint;(f) Observations and monitoring of the consumer during the restraint;(g) Comments resulting from the evaluation of the restraint. | PA Low | Procedures around monitoring and observation of restraint use are documented in policy. The use of restraint is linked to the residents’ care plans. Interventions to manage all identified risks were not always documented in the long-term care plans for residents on restraint. | Interventions to manage the risks are not documented in the long-term care plans for three of three residents (on restraint) files reviewed.  | Ensure that interventions to manage assessed risks are documented in the long-term care plans for residents on restraint. 90 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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End of the report.