

Lifeline Agedcare Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Lifeline Agecare Limited
Premises audited:	Palm Grove Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 November 2016 End date: 1 November 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:	15

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Palm Grove provides rest home level care for up to 30 residents and on the day of the audit there were 15 residents. The service is managed by a manager/registered nurse. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of 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 residents and staff files, observations, and interviews with residents, management and staff.

The service has addressed three of the five shortfalls from the previous certification audit around essential notification to statutory authorities, clinical interventions and medication management. Improvements continue to be required in relation to the quality and risk management programme and clinical assessments.

This surveillance audit identified that improvements are required in relation to reviewing health and safety policies, the employment process, staff orientation, and InterRAI training.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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 medium or high risk and/or unattained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A nurse manager/registered nurse is responsible for the day-to-day operations of the facility. Quality and risk management processes are established. Adverse, unplanned and untoward events are responded to in an appropriate and timely manner. An education and training programme for staff is underway. A registered nurse is available either on site or on call twenty-four hours a day, seven days a week.

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.
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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The care plans are resident and goal orientated with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months. The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are regular entertainers, outings and celebrations. Medications are managed appropriately in line with accepted guidelines. Registered nurses and healthcare assistants who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner. Residents' food preferences and dietary requirements are identified at admission. All meals are cooked on site.

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.
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A current building warrant of fitness is posted in a visible location.

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.
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The service has alternative systems available so that staff can use restraint as a last resort strategy. There were no residents using enablers or restraints. Staff receive education around restraint minimisation.

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.
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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.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	1	2	0	0
Criteria	0	35	0	4	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are accessible to residents and family. A suggestions box is at the entrance to the facility. Information about complaints is provided on admission. Interviews with five residents confirmed their understanding of the complaints process. The nurse manager and four staff (two healthcare assistants, one registered nurse, one cook) could explain the process around reporting and responding to complaints.</p> <p>The complaints register includes verbal and written complaints. Evidence was sighted to confirm that complaints are being managed appropriately including acknowledgement, investigation, corrective actions when required, and resolution. Two complaints have been received in 2016. One of the two complaints remains open with the DHB. Corrective actions have been implemented and the DHB is monitoring progress.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/health issues arises. Ten incident/accident forms were reviewed and identified that the next of kin were contacted or if not, justification as to why. Family were not available for interviewing during the audit.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Access to interpreter services is available if needed for residents who are unable to speak or understand English. There were four residents with English as their second language. Staff and families are available to interpret for these residents.</p> <p>The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Palm Grove provides rest home level of care for up to 30 residents. On the day of the audit there were 15 residents. All 15 residents were on the aged residential care contract.</p> <p>The nurse manager is a registered nurse (RN) who began her employment at the facility in August 2016. Previous roles included aged care management palliative care nursing. The nurse manager reports to the owner, who has a business investment background. The owner is onsite approximately five days a week for an hour each day. In addition to the nurse manager, a registered nurse is employed two days a week and commenced employment in October 2016.</p> <p>The quality and risk management plan includes annual goals. Goals are regularly reviewed by the nurse manager and the owner.</p> <p>The nurse manager has attended a minimum of eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>A quality and risk management programme 2014-2016 has been established. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read the policy and that it is understood. Policies and procedures have been updated to reflect implemented InterRAI procedures.</p> <p>Quality data is collected but is not consistently collated. An annual internal audit schedule is established but is not routinely implemented. Staff meeting minutes do not reflect adequate detail about quality and risk management results. These previously identified areas for improvement remain. Corrective actions are developed, implemented and evaluated where opportunities for improvements are identified.</p> <p>Falls reduction strategies include staff knowing the residents who are at risk, managing challenging behaviours, adhering to residents' routines and anticipating their needs. Processes are in place for accident and incident reporting, injury prevention and management, workplace inspections, and hazard management.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The service collects data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is linked to the quality and risk management programme (link to finding 1.2.3.6). Once incidents and accidents are reported, the immediate actions taken are documented on incident forms. The incidents forms are then reviewed and investigated by a registered nurse. If risks are identified, they are processed as hazards. Non-witnessed falls and any suspected head injury includes observations and monitoring vital signs.</p> <p>The nurse manager is aware of statutory reporting obligations and provided examples of when this would be required. This is an improvement from the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Job descriptions are documented for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of both RNs were current. Five staff files were selected for review (one RN, and four healthcare assistants). Evidence of signed employment contracts, and job descriptions were noted in staff files. All potential candidates are interviewed and police vetted. Reference checking is not regularly conducted.</p> <p>Interviews with care staff described the orientation programme that includes a period of supervision. Missing, was documented evidence of completed orientation programmes.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. The nurse manager is undergoing her InterRAI training. No other InterRAI trained staff are available.</p> <p>A minimum of one care staff is available 24/7 with a current first aid/CPR certificate.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The full-time nurse manager is supported by an RN who was employed in October 2016. The nurse manager reported that the RN's hours will increase to three days a week once occupancy increases to 20 residents. An RN is on call if not available on site 24 hours a day, seven days a week. On call is shared between the nurse manager and RN.</p> <p>Adequate numbers of healthcare assistants are rostered with a separate caregiver cleaning roster. Residents</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>interviewed advised that they felt there was sufficient staffing in the rest home.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. One resident was self-administering inhalers on the day of audit. The resident has been assessed as competent to administer the medication, a consent form has been signed and the medication was stored appropriately. There are no standing orders. All medications were secure and appropriately stored. The facility uses an electronic charting system and medications are dispensed in a pack. Registered nurses and healthcare assistants who have passed their competency administer medications. Medication competencies are updated annually. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication profiles reviewed were legible, up-to-date and reviewed at least three monthly by the GP. All medication charts had photo IDs. All ten medication charts reviewed have 'as needed' medications prescribed with an individualised indication for use. Staff had signed for all medications. Previous findings around dating eye drops, expired medications and securely storing medication have been addressed. The medication fridge has temperatures recorded daily and these are within acceptable ranges.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs one cook (Monday-Saturday) and a meal is left prepared for Sunday for the healthcare assistants to cook. The healthcare assistants also heat up the evening meals. Food temperatures are checked. The cook holds a food safety certificate. The cook oversees the procurement of the food and management of the kitchen. There is a well equipped kitchen and all meals are cooked onsite. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Kitchen fridge, food and freezer temperatures were monitored and recorded daily. These were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs are communicated to the kitchen. Special diets were noted on the kitchen noticeboard, which is able to be viewed only by kitchen staff. The four weekly menu plan has been approved by a dietitian.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and</p>	<p>FA</p>	<p>Care plans reviewed were comprehensive and evidenced multidisciplinary involvement in the care of the resident. All care plans were resident centred and documented support needs to achieve the resident goals. Residents stated they were involved in the care planning process.</p> <p>Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There was evidence of service</p>

<p>promote continuity of service delivery.</p>		<p>integration with documented input from the podiatrist, wound care nurse and the mental health team.</p> <p>A previous finding around short-term care plans not having intervention resolved or updated in the long-term plan has now been met.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>All five care plans reviewed included documentation that meets the need of the residents, and all care plans had been updated as residents' needs changed. Healthcare assistants and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place. There is currently one chronic leg ulcer and no pressure injuries. Appropriate care of the chronic leg ulcer is documented and provided. Access to specialist advice and support is available and the DHB wound care nurse has visited regarding the chronic leg ulcer. Monitoring forms are in use such as weight, blood pressure and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are two activities assistants who work 20 hours between them. One is a certified yoga teacher and the other has considerable experience as an activities assistant. One other assistant comes in twice a week to do gentle exercises and games. The residents also do a gentle yoga routine. On the day of audit, residents were observed being actively involved with a quiz and helping in the dining room. The activities programme is developed monthly and displayed in large print on the residents' noticeboard. Residents have an assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, family, culture etc. Resident files reviewed identified that the individual activity plan is reviewed at least six monthly. Church groups visit fortnightly. There are fortnightly van outings and monthly entertainment. All residents are encouraged to attend community events/groups. There is an outdoor area where residents may sit and enjoy the outdoors. The facility is very close to the beach so walks and picnics are encouraged.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Three care plans reviewed had been evaluated by a registered nurse six monthly or when changes to care occurred. Two care plans were overdue for review (link to finding 1.3.3.3). Short-term care plans for short-term needs were evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are evaluated six monthly. Staff stated that family members are informed of any changes to the care plan and this was evidenced in the family/whānau forms.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location (expiry 21 August 2017).</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Infections are documented on a monthly register by the infection control coordinator (nurse manager). Infection control data is not reported at the quality, infection control or staff meetings and analysis of surveillance data was incomplete (link to finding 1.2.3.6).</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint minimisation policies and procedures are in place. The use of restraint is regarded as a last intervention when all other interventions have not worked. The nurse manager is the designated restraint coordinator. There were no residents using restraint or enablers at the time of the audit. Staff received regular education and training around restraint minimisation.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Adverse event data (falls, skin tears, staff accidents, pressure injuries, infections) is collected but is not routinely collated or analysed. The internal audit programme is not being completed as per the audit schedule. Results are not regularly communicated to staff.</p>	<p>i) Adverse event data for falls, skin tears, bruising, staff accidents, medication errors, and infections has not been consistently collated, analysed or evaluated to identify any possible trends.</p> <p>ii) Only six of thirty-two internal audits have been completed as per the 2016 internal audit schedule. The nurse manager reports that since she has been employed she has been the only RN (August-October 2016) and has not had time to complete internal audits. A second RN was employed in</p>	<p>i) Ensure data collected is regularly collated, analysed, and evaluated.</p> <p>ii) Ensure the audit schedule is completed as planned.</p> <p>iii) Ensure</p>

			October. iii) Staff meeting minutes reviewed do not reflect adequate detail regarding quality and risk data results.	staff are kept informed regarding quality and risk management results. 60 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	The appointment process includes interview and police vetting but does not consistently involve reference checking.	Four of five staff files selected did not indicate reference checking had occurred.	Ensure reference checks are completed as part of the appointment process. 90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	As per policy, new staff are expected to undergo an orientation programme that covers both general and job specific duties. Competencies are completed for medication, hand washing and manual handling, evidenced in all five staff files. One of five files reviewed evidenced completed orientation checklists. The healthcare assistants interviewed reported that they all complete an induction programme, which includes a period of supervision.	Four of the five staff files reviewed did not include documented evidence to support completion of the orientation programme.	Ensure staff files reflect documented evidence of staff completing an orientation programme. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and	PA Low	An education and training schedule is in place for staff that includes both mandatory and job specific education. Over eight hours per year are offered. Interviews with	There are no RNs trained in InterRAI. The nurse manager is currently undergoing training.	Ensure a minimum of one nurse is

<p>record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>staff confirmed that the education provided is interesting and informative. Presently, there are no registered nurses trained in InterRAI (link to 1.3.3.3).</p>		<p>available who is trained in InterRAI.</p> <p>90 days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>There are policies around completing assessments, long-term care plans and long-term care plan evaluations. A range of assessments including falls and pressure area risk assessments are completed, but pain assessments are not consistently completed. All long-term care plans had documented timeframes but not all long-term care plans had documented evaluations six monthly or more often as needed. Wound care plans are well documented.</p>	<ul style="list-style-type: none"> i Two out of five resident files have long-term care plans which are overdue for review; and ii A resident has chronic back pain and is on regular pain medication but no pain assessments have been completed. 	<ul style="list-style-type: none"> i Ensure long-term care plans are evaluated at least six monthly; and ii Ensure residents with chronic pain and who are on regular pain medication, have pain assessments completed. <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.