# Lifecare Funds Limited - Kolmar Lodge Rest Home

## 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](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:** Lifecare Funds Limited

**Premises audited:** Kolmar Lodge Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 15 March 2017 End date: 15 March 2017

**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:** 20

# 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

Kolmar Lodge Rest Home is one of three facilities privately owned and operated by the current owner/directors. The service provides rest home level of care for up to 26 residents. On the day of the audit there were 20 residents.

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, family, management, staff and the general practitioner.

The owner/directors are supported by a manager, assistant manager, two registered nurses and a stable workforce. Residents and family interviewed were complimentary of the service and care they receive.

Two previous findings at certification audit around the admission agreement and ‘as required’ medications have been addressed.

There were no areas for improvement at this surveillance audit.

## Consumer rights

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| 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. |

Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs and family state that they are fully informed at all times. Three-monthly resident/relative meetings provide a forum to discuss any issues or concerns. The complaints procedure is provided to residents and relatives as part of the admission process.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Kolmar Lodge has an implemented quality and risk management system. Key aspects of the quality improvement and risk management programme include: monitoring of incidents and accidents, health and safety, implementation of an internal audit schedule and surveillance of infections. There is an annual family satisfaction survey. The service has policies and procedures that are reviewed by an external consultant. The service has human resources procedures for staff recruitment and employment. There is an implemented orientation programme and an implemented annual training schedule in place.

## Continuum of service delivery

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

The registered nurse is responsible for each stage of service provision. A registered nurse assesses and reviews each resident’s needs, outcomes and goals at least six-monthly. The interRAI assessment tool has been fully embedded. Care plans demonstrated service integration and included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior carers responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three-monthly.

The diversional therapist and activity coordinator implements the activity programme for the residents. The programme includes community visitors, outings and activities that meet the individual and group recreational preferences for the residents (including residents under 65 years of age).

Residents' food preferences and dietary requirements are identified at admission. All meals and baking are cooked on-site. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines. Dislikes and special dietary requirement are met.

## Safe and appropriate environment

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

The building holds a current warrant of fitness.

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

There is a restraint policy that includes comprehensive restraint procedures. There are clear guidelines in policy, which include documented definitions of restraints and enablers that align with the definitions in the standard. There are currently no residents requiring enablers or restraints. Staff receive training on restraint minimisation and managing challenging behaviours.

## Infection prevention and control

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| 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. |

Responsibility for infection control is shared between the nurse manager and a registered nurse. The infection control officers have attended external education and coordinate education and training for staff. Information obtained through surveillance is used 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.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 17 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 42 | 0 | 0 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| 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 how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms and a locked suggestions box is located at the entrance to the facility. A record of all complaints received is maintained by the duty manager using a complaints register. Three complaints were received in 2016 and all were followed up and resolved. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Two caregivers interviewed were able to describe the process around reporting complaints. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff around open disclosure. Five residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Twelve accident/incident forms for January and February 2017 were reviewed and all evidenced open disclosure. Family are kept informed of any accident/incident unless the resident has consented otherwise. Two family members interviewed stated they were kept informed. Interviews with the duty manager and registered nurse (RN) confirmed family are notified following changes in health status.  Three-monthly resident/relative meetings provide a forum for residents to discuss issues or concerns on every aspect of the service. Access to interpreter services is available if needed although have not been required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Kolmar Lodge provides care for up to 26 rest home level residents and on the day of audit there were 20 residents at the facility. It is one of three aged care facilities owned by two directors. In addition to the Aged Related Residential Care (ARRC) contract, the facility holds a Long Term Chronic Support (LTCS) contract with the DHB. There were two residents under the age of 65 under this contract.  There is a 2016-2018 business plan in place that has been reviewed annually. The plan outlines objectives for the period that includes increasing occupancy rates to 98%, staff education, ongoing maintenance plan and utilisation of the outdoor areas for activities. A five-year development plan includes an upgrade of car park concrete, refurbishment of the main lounge, laundry and bedrooms, new indoor/outdoor furnishings and upgrade of administration system.  A duty manager (non-clinical) reports to the directors and is supported by an assistant manager and two RNs. The RNs have appropriate experience to meet the clinical needs of the residents. The duty manager has been in the role for seven years and works on a full-time basis across the three facilities. The majority of her time is at Kolmar Lodge. She is a qualified diversional therapist and in addition to her responsibilities as duty manager, she is responsible for oversight of the activities programme at all three facilities.  The duty manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management system is in place. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. A document control system is in place to manage policies and procedures.  Quality data and outcomes are taken to the bi-monthly integrated committee meetings and then to the bi-monthly staff/meetings. Meeting minutes demonstrate key components of the quality management system, including internal audit, infection prevention and control, incidents (and trends) and in-service education. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicate issues raised are followed through and closed out, including three-monthly resident/relative meetings. Issues arising from internal audits are reported on the audits action sheet and were sighted to have been closed out.  An annual resident/relative satisfaction survey is completed. There is a health and safety and risk management programme in place including policies to guide practice. The duty manager is the health and safety officer. Staff accidents and incidents and identified hazards are monitored. 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 service has lifting belts, hip protectors and access to sensor mats if necessary. |
| 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 | The service collects incident and accident data and reports aggregated figures to the bi-monthly integrated committee meetings and staff meetings. Incident forms are completed by staff who either witnessed an adverse event or were the first to respond. The resident is reviewed by the RN at the time of event. Twelve incident forms were reviewed and all were completed in full. The residents’ files reviewed demonstrated all documented accident/incident forms had the events documented on an accident/incident log, held in the front of the applicable resident’s file and in the resident’s progress notes.  Discussions with the duty manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no reports to the DHB or HealthCert. There have been no outbreaks. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. The RN’s practising certificates were current. All five staff files reviewed (one duty manager, one assistant manager/activities, one RN, two caregivers) had relevant documentation relating to employment. Annual performance appraisals were completed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.  The orientation programme includes documented competencies and induction checklists. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. There is an annual education plan that is being implemented that includes selected competencies that must be completed by staff. There is one RN trained in interRAI to complete new residents’ assessments and one RN is currently undertaking interRAI training. There is a minimum of one care staff with a current first aid certificate on every shift. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows: three caregivers in the morning (varying times), two during the afternoon (varying times) and one on night shift. The duty manager works approximately 20-25 hours/per week at Kolmar Lodge and the remainder (up to 40 hours) at the other two facilities. The RN works approximately 32 hours/week and a second RN 8 hours/week. There is an RN on call 24/7. The activities programme is delivered primarily by the assistant manager and caregivers. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times. |
| 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. Information packs are provided for families and residents prior to admission. There is one admission agreement for both subsidised and private paying residents that includes a schedule of charges that aligns with the ARC contract. The previous finding has been addressed. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs and senior caregivers who administer medications complete annual medication competencies. Annual in-service education on medication is provided. Medications (robotic rolls for regular medications and blister packs for ‘as required’ medications) are checked on delivery against the medication chart and any discrepancies are fed back to the pharmacy. All medications are stored safely. Expiry dates are checked regularly. Standing orders are not used. Three self-medicating residents (inhalers) have a self-medication competency completed and reviewed by the GP three-monthly. The medications fridge temperature is monitored weekly. Eye drops are dated on opening.  Ten pharmacy generated medication charts were reviewed. All medication charts have photo identification and an allergy status. The GP reviews the medication charts at least three-monthly. The administration signing sheets reviewed identified medications have been administered as prescribed. All ‘as required’ medication have a prescribed indication for use. The previous finding around ‘as required’ medications has been addressed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals and home baking is prepared and cooked on-site by the cook on duty. Both cooks have completed food safety training and updates. There is a four-week seasonal menu which has been reviewed by a dietitian. The chef receives dietary profiles for new residents and is informed of any changes to resident’s dietary needs. Likes and dislikes are accommodated. Additional or modified foods such as soft/pureed foods and vegetarian meals are provided. Residents and family members are complimentary about the meals provided.  Meals are prepared in a kitchen adjacent to the dining room and served directly to the residents. Fridge and freezer temperatures are monitored and recorded daily. End cooked temperatures are taken and recorded. The serving temperatures of pureed meals are recorded. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the RN 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 including (but not limited to): accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the discussion with family form in the resident files reviewed.  Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound care flow chart and wound evaluation notes were in place for two residents with wounds. There were no pressure injuries. There is access to the DHB wound nurse specialist for advice for wound management as required.  Continence products are available. The residents’ files include a urinary continence assessment, bowel management plan and continence products used. Monitoring occurs for blood pressure, weight, blood glucose levels, pain monitoring charts and challenging behaviours.  The care staff stated there is adequate communal equipment available to safely provide the care required to meet the resident’s needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The duty manager and assistant manager share the implementation of the activity programme Monday to Friday. The company employs a qualified diversional therapist (DT) to oversee activities across the three facilities in the area. The activity team attend regional activities workshops. The van driver and the activity team have current first aid certificates.  Group activities occur in the mornings and one-on-one activities in the afternoons Activities provided meet the residents’ recreational preferences. Activities are meaningful and include (but are not limited to): reading and discussions, quizzes, walks, exercises, baking and bingo. Community visitors include monthly entertainers, weekly church services, college students, volunteers and RSA. All festivities and birthdays are celebrated. There are regular outings into the community including the Cossie club, swimming, Zumba classes and attending the gym. Residents are supported to attend their own church and other community functions.  Residents under 65 years of age have individualised activity plans that include meaningful activities for the residents around the home such as assisting with the recycling and gardening. The residents also have visiting keyworkers to assist them to access community services and events.  There is one day-care resident Monday to Friday who joins in with the rest home activity programme.  A resident activity assessment and social history is completed on admission. Each resident has a 24 hour individual activity plan which is reviewed six-monthly. The service receives feedback on activities through one-on-one feedback, resident’s meetings and surveys. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six-monthly for the five residents. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. |
| 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 16 March 2018. There are plans to refurbish and renovate internal areas of the facility including toilet/shower areas. Three double rooms have been cordoned off and are currently undergoing full refurbishment. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (RN) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at integrated committee meeting and at handovers. The service completes monthly and annual comparisons of infection rates for types of infections. Trends are identified, analysed and preventative measures put in place.  Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers including definitions. The RN is the restraint coordinator and is knowledgeable regarding this role. During the audit, there were no residents using a restraint or an enabler. Staff receive training around restraint minimisation and managing challenging behaviours. |

# 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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| No data to display |

# 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.