Park Lane Retirement Village Limited

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Park Lane Retirement Village Limited
Premises audited:	Park Lane Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 April 2015 End date: 17 April 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 51

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Park Lane Retirement Village is part of the Arvida group and is managed by an experienced facility manager with support from a clinical manager. The service provides rest home and hospital level care for up to 87 residents. On the day of the audit there were 51 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 and staff.

The service has addressed three of the five findings from the previous certification audit around incident documentation, outbreak reporting and medication competency. Further improvements are required in relation to aspects of care planning.

This audit has identified improvements required around self-administration of medications and evaluations of resident's care plans and activity plans.

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.

Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

Organisational management

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

Risk management processes are practised to promote the safety of residents and staff. Park Lane is committed to continuous improvement processes as demonstrated in quality planning including a review of annual objectives, regular internal audits and the collection of data related to the reporting of adverse events. Quality improvement processes are monitored and information is shared with staff. Policies and procedures are in place for the recruitment of staff. Orientation of new staff is comprehensive and addresses all key policy areas. Regular in-service staff training is provided and is well attended. Staffing levels meet contractual requirements.

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.

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. 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.

The service displays a current building warrant of fitness which expires on 29 February 2016.

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.

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There are two hospital residents using an enabler and one resident with restraint.

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 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	13	0	3	1	0	0
Criteria	0	36	0	3	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
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 and procedures in place and residents and their family/whanau are provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained with all documentation which shows that complaints are managed and resolved. Three complaints received during 2014 and one in 2015 to date have been managed and resolved. Residents and family members advised that they were aware of the complaints procedure and how to access forms.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Four residents (two rest home and two hospital) and four family members (one rest home and three hospital) interviewed stated they are informed of changes in health status and incidents/accidents. A sample of incident reports for April 2015 document family were notified. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur three monthly and the facility manager, clinical nurse manager and registered nurses have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken

conducive to effective communication.		English that the interpreter services are made available. All residents were English speaking on the day of audit.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Park Lane retirement village merged with the Arvida group in December 2014. An experienced facility manager is employed to oversee the running of the service. The facility manager was the previous owner/manager and has been in the role since opening in January 2013. The facility manager has an extensive background in management. The facility manager now meets with chief executive officer of the Arvida group two monthly and reports on a variety of management issues. The facility manager is supported by a full time clinical manager who is a registered nurse and has a background of working in aged care. The clinical manager has recently been appointed to the position having been a registered nurse at the service for two years. Park Lane is certified to provide rest home and hospital level care for up to 87 residents. On the day of the audit, there were 32 rest home residents (10 of whom reside in a service/studio apartment) and 19 hospital level care residents. There were no residents on respite care. The service has a business plan in place (2015-2018) for organisational governance and direction. The current strategic plan and quality and risk management plans have been implemented. The facility manager has attended in-service and external education in the past 12 months to comply with contractual requirements.
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	The quality manual and the business, quality, risk and management planning procedure describe Park Lane's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the two monthly quality improvement meeting, and the various facility meetings. Monthly and annual reviews are completed for all areas of service. Meeting minutes are maintained and staff are expected to read the minutes which are readily available in the staff room. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses (two, one of which is a charge nurse), one enrolled nurse and three health care assistants confirm their involvement in the quality programme. Resident/relative meetings are held three monthly. Restraint and enabler use is reported within the quality improvement and clinical meetings. Data is collected on complaints, accidents, incidents, infection control and restraint use. There is an internal audit schedule which is being implemented. Areas of non-compliance identified at audits are actioned for improvement. The service employs a registered nurse to oversee the quality programme and education programme. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. Staff read and sign any changes to policies. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in

		a timely manner. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.
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	Incident and accident data is collected and analysed. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for April 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. Reports were completed. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service notified relevant authorities of an outbreak in January 2015 within the required time frame. This was a previous audit finding that has now been addressed.
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	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 are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (clinical manger, RN charge nurse, laundry, healthcare assistant, cook and activities coordinator) and all files included all appropriate documentation. Staff turnover was reported as high initially but has decreased and staff have been more stable over the last 12 months. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Healthcare assistants are orientated by the quality assurance/ educator staff member and then buddied with an experienced healthcare assistant. Annual appraisals were conducted for all five staff that were eligible. There was a completed in-service calendar for 2014 which exceeded eight hours annually. An in-service schedule for 2015 was in place and being implemented. Healthcare assistants have completed either the national certificate in care of the elderly or have completed or commenced an aged care education programme. This is compulsory as part of the employment contract. Two healthcare assistants have completed the national certificate in aged care and

		14 have completed an aged care programme. Healthcare assistants that administer medications have completed medication competencies. This was a previous audit finding that has now been addressed. The facility manager, clinical nurse manager and registered nurses attend external training including conferences, seminars and education sessions with the local DHB.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Park Lane has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is at least one registered nurse and two healthcare assistants on duty at all times. The full time clinical manager is a registered nurse. Healthcare assistants advised that sufficient staff are rostered on for each shift. Staff turnover is now stable. All registered nurses and are trained in first aid.
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	Medication policies align with accepted guidelines. Medications are signed for when administered and two signatures were evident where appropriate. Medication charts have photo ID's. 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. The medication folders include a list of specimen signatures and competencies. Registered nurses and enrolled nurses administer medications. Medication competencies are completed annually. Medication errors are reported and recorded on incident forms. Registered nurses interviewed could describe the self-medication policy. There were three residents self-administering medication. Residents were reviewed by the GP and a registered nurse as being competent; however, reviews of competency did not occur three monthly as per the policy for two of three residents. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. Residents/relatives interviewed stated they are kept informed of any changes to medications and doctors reviews. Indications for medications are recorded by the GP on the medication charts where appropriate. Ten of ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. Medication audits are completed six monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	The facility has a large workable kitchen in a service area on the ground floor. The menu has been designed and reviewed by a Registered Dietician. Food is transported in insulated food carriers to the kitchen on each floor. There are two cooks. Both cooks had

Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		attained NZQA standard 167- food safety certificates. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or sooner if required. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook. Special diets are noted on the kitchen notice board, which can be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets, high protein, and vegetarian. Residents are able to provide feedback to the service. Daily temperature checks are maintained. Residents interviewed reported satisfaction with the food service.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission, which forms the basis of resident goals and objectives. A range of assessment tools are completed at admission and reviewed at least six monthly. Two of five files did not have a documented assessment tool for nutritional needs and therefore the previous audit finding remains. Two registered nurses have completed InterRAI training.
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	Two of five care plans reviewed were current and interventions reflect the assessments conducted and the identified requirements of the residents. Two of five care plans did not record detail interventions for a specific medical condition and one of five files did not record intervention to manage the risks of enabler use. Two care plans recorded interventions in the evaluation section and changes were not transferred to the body of the care plan. Interviews with the registered nurse, caregivers, and residents evidence residents input when interventions are planned. Appropriate supplies are in stock and resident files include a urinary continence assessment, bowel management, and continence products are identified for day use, night use, and other management. Specialist continence advice was available as needed and this could be described. Wound assessment and wound management plans were in place for all residents with wounds; however, wound management did not occur for two residents according to the frequency stated in the care plan; therefore the previous audit finding remains.
Standard 1.3.7: Planned Activities Where specified as part of the service	FA	The activities staff provided an activities programme over five days each week. Activities planned for the day were displayed on notice boards around the facility. An activity plan is developed for each individual resident based on assessed needs; however, two of five care plans have not been evaluated (# link to1.3.8.2). Residents were encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in

delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		community activities. The service has a van that is used for resident outings. Residents were observed participating in activities on the day of the audit. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Care plan evaluations reviewed were comprehensive. Three of five care plans reviewed were updated as changes were noted in care requirements; however; two evaluation statements have interventions that were not transferred to the care plan (# link 1.3.6.1). Two activities care plans were not evaluated since admission and therefore continues to require improvement. Short-term care plans are utilised for residents with short-term health issues. Three of five files evidence sufficient detail in the short-term care plan to guide care staff. This was a previous audit finding that has now been addressed. Any changes to the long term care plans were dated and signed. Two of five care plans were not evaluated within the required time frames.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is a current building warrant of fitness which expires 29 February 2016.
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	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. The clinical manager is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly facility infection summary and staff are informed. This data is monitored, evaluated monthly and discussed at the two monthly quality meeting. There has been an outbreak in January 2015 involving 13 residents and five staff. The outbreak was effectively managed and reported to relevant authorities within the required time frame. Outbreak management training has been completed for all staff.

control programme.		
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint policy is in place. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment, consent, monitoring and evaluation of enabler use is the same as a restraint and included in the policy and were evident in the three files reviewed (# link 1.3.6.1). The service has one hospital resident with bedrail restraint. The service has two hospital residents using bedrails as enablers. Enablers are assessed as required for maintaining safety and independence. Enablers are used voluntarily. Training has been provided around restraint minimisation, enablers and challenging behaviours. The restraint standards are being implemented and implementation is reviewed through internal audits and facility 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	The facility has a self-medication administration policy and the registered nurses could describe this. Residents are reviewed as competent to self-administer medication.	Two of three residents were not reviewed three monthly as competent to self-administer medication.	Ensure residents that are reviewed three monthly as competent to administer their own medication. 30 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery	PA Low	Nursing assessments are completed and is updated when the care plan is evaluated. Two of the five files did not have nutritional assessment completed.	Two of the five files reviewed did not have any nutritional assessments completed.	Ensure that all residents have a nutritional assessment completed. 60 days

planning.				
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Two files recorded comprehensive interventions to guide staff in the care of the residents. Interventions reflect the needs of the residents. Wound management plans were evident in the residents` files.	(i)Interventions appropriate for specific medical conditions were not documented in detail for two of five residents; ii) One resident did not have appropriate interventions to manage risk for enabler use; iii) The frequency of wound management for two residents did not occur as planned; and iv) Two files evaluation statements included interventions, which were not transferred to the body of the care plan.	(i)Ensure interventions recorded in detail to guide staff in the care of the resident; ii) Ensure care plans record the management of risks for enabler use; iii) Ensure monitoring of wounds occur as planned; and iv) Ensure that all changes in interventions are transferred to the care plan, once evaluated. 60 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Evaluations are comprehensive and refer to the individual goals for all residents. Activity plans are evaluated six monthly in three of the five files reviewed. Two activities care plans were not evaluated.	(i)Two files were not evaluated within the required time frame. (ii)Two files not did evidence any evaluations against the goals of the activity plan.	Ensure that care plans and activity plans are evaluated at least six monthly. 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.

No data to display

End of the report.