# The Whalan Lodge Trust

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** The Whalan Lodge Trust

**Premises audited:** Whalan Lodge

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

**Dates of audit:** Start date: 1 May 2015 End date: 1 May 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:** 4

# 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

Whalan Lodge is a 14 bed rest home. The facility is governed by a community trust board. On the day of the audit there were four residents. Whalan Lodge is managed by a registered nurse who has been in the role for one year. The nurse manager is also supported by an assistant manager/cook, care staff, trust board members and community volunteers. Family and residents interviewed spoke positively about the care and support provided.

This certification audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

Improvements are required around professional development for the nurse manager, orientation of new staff and employment documentation, assessments, evaluation of care plans and aspects of the food service.

## 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. |

The staff at Whalan Lodge strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Policies are implemented to support residents’ rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

The nurse manager is a registered nurse and she is supported by an assistant manager/cook, care staff, board members and community volunteers. The nurse manager has been in the role for one year. The implemented quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Internal audits are completed as per the audit schedule. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Discussions with families identified that they are fully informed of changes in health status. In-service education has been provided that covers relevant aspects of care and support and all employees have an annual staff appraisal. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The systems reviewed evidenced each stage of service provision was developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. The residents interviewed confirmed that interventions noted in their care plans were consistent with meeting their needs.

A sampling of residents' clinical files validated the service delivery to the residents. Initial care plan is conducted on admission. Where progress was different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan. Care plans are evaluated six monthly.

The residents' files evidenced individual activities were provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management have current medication competencies. There were no residents who self-administer medicines at the facility.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. There is a kitchen and on site staff that provide the food service.

## 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. |

Whalan Lodge has a current building warrant of fitness. There is a reactive and preventative maintenance at the facility.

Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged to allow residents to mobilise.

There is a designated laundry which includes storage of cleaning and laundry chemicals. There are emergency procedures in place and the service has sufficient supplies for use in an emergency. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and in communal areas. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in a designated external area.

## 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. |

Whalan Lodge has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there was one resident with restraint and no enablers. Restraint documentation reviewed included assessment, consent, planning and review. The restraint is used infrequently.

## 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. |

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

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 95 | 0 | 4 | 2 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with three caregivers, one assistant manager, and one nurse manager confirm their familiarity with the Code. Interviews with four residents and two relatives confirmed the services being provided are in line with the Code. Code of rights and advocacy training has been provided. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. The informed consent is discussed at the time the resident is admitted to the facility. Staff interviewed demonstrated good understanding of informed consent processes.  Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are obtained, where residents have named EPOAs and these were reviewed on residents’ files.  Residents and family interviewed confirmed they have been made aware of and understand the principles of informed consent, and confirmed informed consent information has been provided to them and their choices and decisions are acted on. Advance directives were recorded and located on residents’ files sampled. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents’ meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Interviews with residents and relatives confirmed that visiting can occur at any time. Family members were seen visiting on the day of the audit. Key people involved in the resident’s life are documented in the care plans. Discussions with residents and relatives verified that they are supported and encouraged to remain involved in the community. Whalan Lodge staff support on-going access to community. Entertainers are invited to perform at the facility. The service is well supported by the governing body and by many community volunteers who provide time and resources. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint’s forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at the entrance. A review of the complaints log/register evidences that the appropriate actions have been taken in the management and processing of complaints. A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service provides information to residents that include the Code, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents and relatives identified they are well-informed about the Code. The nurse manager provides an open-door policy for concerns or complaints. Resident meetings have been held providing the opportunity to raise concerns in a group setting. An annual resident satisfaction survey has been conducted. The survey includes questions relating to complaints process and residents rights, with respondents reporting they were overall satisfied or very satisfied.  Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful and that they are given the right to make choices. Care plans reviewed identify specific individual likes and dislikes. Staff education and training on abuse and neglect has been provided. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a Maori heath plan and an individual’s values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau.  There are no residents at Whalan Lodge who identify as Maori. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau. Cultural awareness training has been provided. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions. Care plans reviewed include the residents’ social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of house rules and a Whalan Lodge code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with staff and management. Interviews with staff confirmed their understanding of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The recent resident satisfaction survey reflects high levels of satisfaction with the services that are received. Policies and procedures have been updated by the previous manager and are available to staff. Staff meetings and residents meetings have been conducted.  Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they feel supported by the new manager and new registered nurse. There are implemented competencies for caregivers. There are clear ethical and professional standards and boundaries within job descriptions. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies are in place relating to open disclosure. Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of incident reports reviewed, and associated resident files, evidenced recording of family notification. Relatives interviewed confirm they are notified of any changes in their family member’s health status. The nurse manager identified the processes that are in place to support family being kept informed. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.  The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | Whalan Lodge is a 14 bed rest home. The facility is governed by a community trust board. On the day of the audit there were four residents. Whalan Lodge is governed by a community trust board. The trust has engaged a nurse manager who maintains an annual practicing certificate. She has qualifications in aged care, primary care and intensive care. The nurse manager has been in the role for the past 12 months and is support by an assistant manager/cook and care staff, the trust board and volunteer members of the community. The service has a current strategic and business plan which includes a philosophy of care, and a current quality and risk management plan. A quality management system is being implemented which includes gathering data and information to provide opportunities for quality improvement. The nurse manager has completed education and training around clinical care but has not completed professional development in relation to managing a rest home |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the nurse manager, the assistant manager is in charge with support from the board. A review of the documentation, policies and procedures and from discussions with staff identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality. |
| 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 business plan and quality and risk management programme describe Whalan Lodge’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 by the nurse manager and assistant manager and discussed at general monthly staff meetings. Monthly and annual reviews have been completed for all areas of service. Meeting minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with the caregivers confirmed their involvement in the quality programme. Resident/relative meetings are held. Restraint and enabler use is reported within the staff meetings.  Data is collected on complaints, accidents, incidents, infection control and restraint use. There is an internal audit schedule which has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. 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 which have been provided by an external consultant. Policies and procedures align with the client care plans. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly and updated externally. The death/Tangihanga policy and procedure 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 | There is an accidents and incidents reporting policy. A sample of incident reports reviewed for 2015 evidenced that all forms were completed and signed off, clinical follow up had been conducted with appropriate assessments, and referrals and care planning completed. Accidents and near misses are investigated by the nurse manager and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff meetings including actions to minimise recurrence. Clinical follow up of residents is conducted by a registered nurse. Discussions with the manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and family members interviewed stated they are informed of changes in health status and incidents/accidents. Family notification was recorded on incident forms and in progress notes reviewed. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resource management policies in place which include recruitment and staff selection processes that require that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurse and general practitioners is kept. Six staff files were reviewed and evidence that reference checks are completed before employment is offered for three of the six files reviewed. The service has an orientation programme that provides new staff with relevant information for safe work practice. Three new staff members employed in the last three months do not have completed orientation documentation on file and three care staff files did not evidence signed job descriptions. The nurse manager also does not have a signed job description or contract on file. In-service education programme for 2014 has been completed. Caregivers have completed an aged care education programme. The nurse manager has attended training including sessions provided by the local DHB (link #1.2.1.3). Annual staff appraisals were evident in staff files reviewed. Six monthly fire evacuation drills have been conducted. |
| 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 policy that includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home residents. There is at least one staff rostered on at any one time with one staff on-call. The nurse manager works up to 25 hours per week and the nurse manager and a registered nurse from the local medical centre (both trained in primary response in a medical emergency PRIME) share on call after hours and weekends. Extra staff can be called on for increased resident requirements. Interviews with caregivers, residents and family members identify that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files sampled are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ station. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care giver or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry and assessment processes are recorded in resident files sampled. This facility operates 24 hours a day, seven days a week. The facility information pack is available for residents and their family and contains all relevant information.  The residents' admission agreements sampled evidenced resident and /or family and facility representative sign off. The needs assessments were completed for rest home level of care in files sampled. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There was appropriate communication between families and other providers in the residents’ files that demonstrated transition, exit, discharge or transfer plans were communicated, when required. Transition, exit, discharge, or transfer form / letters / plan were located in residents' files sampled, where this was required. |
| 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 | The medicine management system meets guidelines and current legislative requirements. In interview, the RN reported that prescribed medications were delivered to the facility and checked on entry. The medication area evidenced appropriate and secure medicine storage and dispensing system. The medication fridge temperatures were conducted and recorded.  All staff authorised to administer medicines had current competencies. The medication round was observed and evidenced appropriate practices were followed. Administration records were maintained in files sampled. Specimen signatures are documented. Staff education in medicine management was conducted.  Four of four medicine charts evidenced residents' photo identification, medicine charts were legible, as required (PRN) medication was identified for individual residents and correctly prescribed, three monthly medicine reviews were conducted and discontinued medicines were dated and signed by the GPs. The residents' medicine charts recorded all medications a resident was taking (including name, dose, frequency and route to be given). There were no residents self-administering medicines at the facility. |
| 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. | PA Low | The food service policies and procedures are appropriate to the service setting. There is a three week rotating seasonal menu that was reviewed by the dietitian in 2013 and in process of being reviewed at time of audit. The cooking is completed by the cook, volunteers and care staff. The cook has completed food safety training. There is evidence the staff have read the food service policies and procedures. Not all staff have completed food safety training. There is inconsistency of taking of food temperatures. Decanted food is not dated. One surface in food preparation area and one in storage area do not meet infection control requirements.  In interviews, the cook and care staff confirmed they were aware of the residents’ individual dietary needs. There were copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the cook.  The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service. The fridge and freezer temperatures are recorded. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | A process to inform residents and family, in an appropriate manner, of the reasons why the service had been declined would be implemented, if required. The residents would be declined entry if not within the scope of the service or if a bed was not available. The resident would be referred back to the referring service as reported by the nurse manager. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | The residents' needs, outcomes and goals were identified via the assessment process and recorded in files sampled. The facility has processes in place to seek information from a range of sources.  The residents' files evidenced residents' discharge/transfer information from DHB (where required) were available. In interview, the RN confirmed that assessments were conducted in a safe and appropriate setting including visits from the doctor. In interviews, residents and family confirmed their involvement in assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The residents’ care plans were individualised, integrated and up to date in files sampled. The care plan interventions reflected the assessments and the level of care required (refer to 1.3.4.2). Short term care plans were developed, when required and signed off by the RN when problems were resolved in files sampled. In interviews, staff reported they received adequate information for continuity of residents’ care. The residents had input into their care planning and review, confirmed at resident and family interviews. Regular GP care was implemented, sighted in current GP progress reports and confirmed at GP interview. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The residents' care plans sampled evidenced interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records were current in files sampled. In interviews, residents and family confirmed their and their relatives’ current care and that treatment meet their needs. Nursing progress notes and observations charts are maintained. In Interviews staff confirmed they were familiar with the current interventions of the resident they were allocated.  Wound care management, treatment and review is based on documented assessment findings and current best practice (refer to tracer 1.3.3). |
| 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 | In interview, the assistant manager (AM) confirmed the activities programme met the needs of the service group and the service had appropriate equipment. The AM confirmed activities were provided by the activities coordinator (AC) until January 2015 when the AC resigned. Since then the activities have been conducted by the AM and NM with support from volunteers. There has been a recent appointment of a new activities coordinator.  The new AC, AM and nurse manager plan, implement and evaluate the activities programme. Interviews with residents, family and staff confirmed the activities programme included input from external agencies and supported ordinary unplanned/spontaneous activities including festive occasions and celebrations. There were current, individualised activities care plans in residents’ files. These are not reviewed six monthly (link 1.3.8.2). The residents’ activities attendance records are maintained. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Time frames in relation to care planning evaluations are documented. The residents' files evidenced the residents' care plans were up-to-date and reviewed six monthly but do not consistently record the degree of achievement to the intervention provided and progress towards meeting the desired outcomes. Activities care plans have not been evaluated six monthly. In interviews, residents and family confirmed their participation in care plan evaluations.  The residents’ progress records were entered on each shift in each file sampled. When resident’s progress was different than expected, the registered nurse (RN) contacts the GP, as required. Short term care plans were in some of the residents’ files, used when required. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services. This included referrals to DHB specialists in files sampled. Family communication sheets confirmed family involvement. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place. All chemicals were labelled with manufacturer labels. There is a designated area for storage of cleaning/laundry chemicals and they are stored securely. Material safety data sheets and product user charts are available and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.  There was provision and availability of protective clothing and equipment that was appropriate to the recognized risks and used by staff. Interviews with caregivers confirmed management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed. There is reactive and preventative maintenance in place. There is a current test and tag programme of electrical equipment and current calibration of clinical/ medical equipment. Interviews with staff and observation of the facility confirmed there was adequate equipment.  Hot water temperature monitoring is conducted monthly and hot water temperature readings are within safe temperature range.  There are quiet areas at the facility for residents and visitors to meet and areas that provide privacy when required. There are outside areas where residents can sit with outside seating and shade provided.  Floor surfaces are appropriate, corridors allow residents to pass each other safely and there is sufficient space to allow the safe use of mobility equipment. Hand rails are appropriately located in the hallways. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible toilets/bathing facilities located at the facility. Visitor’s toilet and communal toilets are conveniently located and have a system that indicates if it is engaged or vacant.  Appropriately secured and approved grab rails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence.  Residents and family interviewed reported that there are sufficient toilets and showers. Fixtures, fittings, and floor and wall surfaces are of accepted material for cleaning purposes. Alcohol hand cleaners were available throughout the facility and at the front door for visitors. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Rooms are personalised. Hallways and communal areas allow wheelchair access. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a dining room and two lounges for residents use with appropriate setting arranged. Residents are able to mobilise freely in these areas. Residents are able to access areas for privacy, if required. The lounge area was observed to be used for activities on day of audit. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are policies and procedures for management of laundry and cleaning practices. The caregivers are responsible for the laundry. Residents and family members confirmed satisfaction with laundry and cleaning services. The sluice is in the laundry. There is a designated area for the secure storage of cleaning and laundry chemicals. Laundry and cleaning processes are monitored for effectiveness via the internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an evacuation plan approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. Fire drills are conducted six monthly. Staff confirmed their awareness of emergency procedures. There is always one staff member on duty with a current first aid certificate.  There are adequate supplies in the event of a civil defence emergency. Alternative heating and cooking facilities are available. A call bell system is installed and available in all resident areas. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.  Night stores are appropriately placed for warmth of the facility, heat pumps are available in lounge areas and the resident bedrooms have a heater available. The service also has wood burners. Family and residents interviewed confirmed the facilities were maintained at an appropriate temperature. There is a designated external smoking area. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Whalan Lodge has an established infection control (IC) programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The nurse manager is the designated infection control nurse with support from the assistant manager and staff (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation and annually. The infection control programme was last reviewed in January 2015. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The nurse manager at Whalan Lodge is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by an external provider and have been reviewed and updated annually. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the on-going education of staff and residents. Formal infection control education for staff has occurred. The nurse manager has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in Whalan Lodge's infection control manual. 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 is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at infection control meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimized. The facility has one resident who has been assessed for restraint in the form of bedrails and a lap belt, this is infrequent. Advised by the nurse manager and confirmed with care staff that the restraint (lap belt or bed rails) are only utilised when necessary. The resident occasionally attempts to mobilise unaided and the restraint is used as a last resort and as a falls prevention measure. When restraint is in use, staff advised that they sit with the resident to ensure that she is safe and in no distress. On review of restraint monitoring, it is noted that the restraint has been used very infrequently. No other residents have restraint or enablers. All necessary documentation has been completed in relation to the restraint. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint use audits have been conducted and restraint has been discussed as part of staff meetings. The nurse manager is the designated restraint coordinator. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The nurse manager is the restraint coordinator. Assessment and approval process for a restraint intervention included the restraint coordinator, resident/or representative and medical practitioner. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the one restraint file reviewed, assessment and consent were fully completed. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for the restraint. The one restraint file reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. In resident files reviewed, appropriate documentation has been completed. The service had a restraint and enablers register which was up dated each month. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every three months. In the restraint file reviewed, evaluations had been completed with the family/whanau, restraint co-ordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the restraint co-ordinator at staff meetings. Evaluation timeframes are determined by risk levels. The evaluations had been completed with the family/whanau, the restraint co-ordinator and the medical practitioner in the file sampled. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint co-ordinator. Any adverse outcomes were included in the monthly staff meetings sighted. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.1.3  The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services. | PA Low | The nurse manager reports to the governing trust board on a monthly basis on a variety of topics relating to quality and risk management. The nurse manager advised that there is regular weekly contact with the board chairman (verified on interview). While the nurse manager has completed education and training relating to nursing and clinical care, professional development relating to managing a rest home has not been completed as per ARC contract requirements. | The nurse manager has not completed eight hours of professional development relating to managing a rest home in the past 12 months. | Provide evidence that the nurse manager has completed at least eight hours of professional development relating to managing a rest home.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Eight staff are employed at Whalan Lodge including caregivers and an assistant manager. Six staff files reviewed evidenced copies of qualifications and medication competencies. Staff appraisals have been conducted for staff after one year of employment and annually thereafter. Two of five files evidenced signed job descriptions. | Three new staff members employed in the last three months do not have completed orientation documentation on file and three care staff files did not evidence signed job descriptions. The nurse manager also does not have a signed job description or contract. | Ensure that all employment processes are completed and documented  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 | The service has orientation processes in place including a buddy system for new staff members to work alongside more experienced staff. The orientation package includes health and safety, infection control and familiarisation with policies and procedures. Two of six staff files reviewed evidence that orientation packages and documentation have been completed. | Four of six staff files reviewed do not evidence that orientation packs have been completed. | Ensure that all new staff complete the orientation and induction programme and that this is recorded.  90 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Kitchen was observed to be clean and tidy. Staff conduct kitchen cleaning and sign off when this is completed. There are two surfaces, one in the kitchen and one in the pantry that do not comply with infection control requirements. Interview with the cook confirmed they have conducted food safety training. | One surface in food preparation area and one in storage area do not meet infection control requirements. Not all staff have completed food safety training. There is inconsistency of taking of food temperatures. Decanted food is not dated. | Ensure that food storage and food preparation comply with legislation and guidelines and staff complete food safety training.  90 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 planning. | PA Moderate | Initial assessments and initial care plans are conducted on admission. Four of four files reviewed evidenced risk assessments have not all been completed and reassessed when required. | Risk assessments and risk reassessments are completed inconsistently. | Ensure that all required risk assessments are completed.  90 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 Moderate | Care plan evaluation are conducted six monthly, however there was evidence the evaluations did not always record the degree of achievement towards meeting the residents’ desired outcomes. Activities care plan were conducted, however they were not evaluated six monthly. | Care plan evaluation does not consistently record the degree of achievement to the intervention provided and progress towards meeting the desired outcomes.  Activities care plans have not been evaluated six monthly. | Ensure that care plan evaluations record the degree of achievement towards meeting resident’s outcomes and that activities care plans are reviewed 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.

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End of the report.