Elmswood Court Lifecare 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:	Elmswood Court Lifecare Limited
Premises audited:	Elmswood Retirement Village
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 July 2016 End date: 8 July 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 57

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

Elmswood Retirement Village is certified to provide care to up to 87 at rest home level care. There were 57 residents on the days of audit. Residents, relatives and the GP interviewed spoke positively about the service provided.

Elmswood is owned by a group of shareholders and managed by a facility manager, who reports to a general manager. A registered nurse and a quality advisor support the manager.

This surveillance audit was conducted against the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, a general practitioner and management.

The service has addressed one of the two previous certification audit findings around assessment of residents. Further improvements are required around care plan interventions.

This audit identified that an improvement is required in relation to aspects of medication management.

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 maintained and this was confirmed on interviews. A system of complaints is available to service users.

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.

There is an implemented quality and risk plan for the service. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Resident meetings are 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. A comprehensive education and training programme has been implemented. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The service's registered nurses develop nursing care plans and have the responsibility for maintaining and reviewing the support plans. Risk assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Care plans are evaluated six monthly or more frequently when clinically indicated. There is documented evidence of allied health involvement into the residents' care.

The activity programme is varied, and reflects the interests of the residents, including community interactions.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. The general practitioner reviews medication profiles three monthly or earlier if necessary.

The menu is designed and reviewed by a registered dietitian. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen.

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.

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.

A restraint policy includes comprehensive restraint procedures. The documented definition of restraint and enablers aligns with the definition in the standards. There are currently no residents with restraint or enablers. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. 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	15	0	0	2	0	0
Criteria	0	38	0	0	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.

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 that describes the management of the complaints process. There are complaints forms freely available to residents and family members. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaints register. Five complaints for 2016 were reviewed. Complaints have been investigated with corrective actions identified. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to raise any concerns.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There are policies and procedures in place relating to accident/incidents, complaints and open disclosure. Families and residents interviewed (two family members and five residents) confirmed they were welcomed on entry and were given time and explanation about the services and procedures. Incidents/accidents forms reviewed include a section to record family notification. All forms sampled indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	A group of shareholders owns Elmswood Retirement Village. The general manager is one of the shareholders. She reports to, and is on the board of directors, which meets three times a year. A facility manager is employed to oversee the running of the rest home and serviced apartments. The facility manager (previous mental health nurse) has been in the role since November 2015. A quality consultant (registered nurse) and a full-time registered nurse support the facility manager. Elmswood Retirement Village is certified to provide rest home level care for up to 87 residents within a 54-bed rest home and in 33 serviced apartments. On the day of audit, the rest home was full with 54 residents and there were three rest home level residents in the serviced apartments. Two of the three residents in the serviced apartments were on respite contracts. All other residents were on the ARC contract. The service has a current business plan, which includes a new hospital level wing, which is in the process of being built. There is a current quality plan. The quality advisor, the manager and RN manage the organisational quality programme. The service has an annual planner/schedule that includes audits, meetings and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The manager has maintained at least eight hours annually of professional development activities related to managing the facility.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Elmswood Retirement Village has a business plan in place for the service. There is a quality programme and a risk management plan, which is reviewed annually. Progress with the quality and risk management programme has been monitored through the quality and risk meeting, monthly health and safety team meetings and infection control meetings. Staff meetings and staff newsletters document the communication of quality data to all staff members. An internal audit schedule is being implemented. The service employs a quality consultant who undertakes and reports on all audits. Areas of non-compliance identified at audits evidenced follow-up for all areas of noncompliance and this has been documented. A monthly analysis of all incidents and internal audit outcomes is completed and a summary is included in the quality and risk meeting minutes and staff newsletters. Policies and procedures are reviewed two yearly by the quality consultant in consultation with relevant staff and content of policies reviewed reflects current and relevant standards, contracts and guidelines. Resident/relative meetings occur two monthly.

		The service has a health and safety management system. There are designated health and safety staff representatives. The service collects information on resident incidents and accidents as well as staff incidents/accidents. Hazard identification forms are completed to identify hazards with actions identified and reviewed/followed-up where appropriate A resident survey and a family survey are conducted annually. The surveys evidence that residents and families are overall very satisfied with the service.
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	Elmswood continues to collect and analyse incident and accident data and report outcomes monthly. A sample of resident related incident reports for June 2016 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data with other facilities. The manager is aware of the responsibilities in regards to essential notifications. An example was provided of a recent section 31 notification.
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 be completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed including two registered nurses, three caregivers, and an activities person. All files included all appropriate documentation. The service has an orientation programme that provides new staff with relevant information for safe work practice and includes three days with a 'buddy'. Staff interviewed were able to describe the orientation process and stated that they believed that new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. There is a completed in-service calendar for 2015 and a plan for 2016 is underway. Training is provided as part of the staff meeting and self-learning packages. The service maintains a series of competencies for all staff including (but not limited to) medication hand hygiene, infection control, health and safety and manual handling. Specific learning tools include restraint, infection control, abuse and neglect. Attendance records were reviewed and evidenced that attendance numbers have improved. All team leaders have a first aid certificate to ensure there is someone on duty at all times with a first aid

		certificate and all staff who administer medications have medication competency. Three registered nurses are InterRAI trained. Registered nurses and caregivers are able to attend external training including conferences and seminars.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Elmswood has a roster in place that ensures that there is sufficient staff rostered. There is a registered nurse on duty Monday to Friday, plus an additional registered nurse who works a four days on, two days off roster. Each shift is led by a team leader (senior caregiver or enrolled nurse) as well at three caregivers each shift during the day and two at night. Core care staffing was reported as stable. Interviews with staff, residents and family identify that staffing is adequate to meet the needs of residents.
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 Moderate	There are medication management policies and procedures in place that follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: medicines care guides for aged residential care. Registered nurses, enrolled nurses and team leaders (senior caregivers) administer medications and they have attended annual medication education. All staff who administer medications have completed an annual medication competency. Regular medications are checked on arrival by an RN. Adhoc changes or new medicine requirements are checked by a team leader where the RN in not available on arrival. Medication fridges are used to store medications requiring refrigeration and are monitored daily. Medication administration was observed and the procedure followed by the registered nurse was correct and safe. The service uses a combination of an electronic medication system and a paper-based system. Depending on the GP, some residents use the computer system and some the paper-based. There were no residents self-medicating at the time of audit. Ten medication charts were reviewed; seven on the electronic medication system and three paper-based. All electronic charts had photo identification and allergy status identified. Not all paper-based charts included allergies. Not all medication is documented as given as prescribed (paper-based). Medication charts had been reviewed at least three monthly by the GP.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked on-site. The two qualified chefs are supported by kitchen staff. The menus are approved at least two yearly by a dietitian. Meals are prepared in a well-appointed kitchen adjacent to the rest home dining room and served directly to residents. Food is transported to the serviced apartment dining room and placed in the bain-marie and served to residents. Kitchen staff were trained in safe food handling and food safety procedures were adhered to. Fridge, freezer and meal temperatures are recorded and action taken as needed. Cleaning schedules are maintained. All foods were dated and stored correctly. Staff were observed delivering meals and assisting residents with their lunchtime meals as required. Diets were modified as required. Food services staff knew resident dietary profiles, likes, and dislikes and any changes were communicated to the kitchen via the registered nurse. Supplements have been provided to residents with identified weight loss issues. Internal audits are undertaken. Food satisfaction surveys are conducted. Resident meetings discuss food as part of their meetings. Interviews with residents and family members indicated satisfaction with the food service.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All residents are admitted with a care needs assessment completed by the needs assessment and service coordination team prior to admission. InterRAI assessments have been completed for three long-term residents (one resident file was for a respite resident and one resident had been admitted within the previous 21 days). Additional paper-based assessments included (but not limited to) dietary needs, continence, falls risk, pressure risk and pain. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives. Assessments are reviewed at least six monthly. Appropriate risk assessments had been completed for individual resident issues. The respite resident had an initial nursing assessment and plan in place. The service has addressed the previous audit findings relating to completion of assessments and reflection of risks into care plans on admission.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs	PA Moderate	When a resident’s condition changes, the RN initiates a GP, or nurse-specialist consultation. There is documented evidence of family notification for a resident change in health status. Five resident files were reviewed including one respite resident in the serviced apartments. Long-term care plans do not reflect all resident needs and short-term care plans are not always documented for short-term/acute needs such as wound and infections. The previous audit finding remains open. Monitoring charts (such

and desired outcomes.		as blood sugar levels and turning charts) have been completed as directed. Dressing supplies are available and a treatment room is stocked for use. Skin and wound assessment/evaluation tools are in place for all wounds however, not all wounds had been re-dressed and evaluated within set timeframes, and not all wound care documentation was complete. There were no short-term care plans in place for the management of all wounds and infections. Photographs and wound evaluations provide a record of the healing progress. Wound management in-service has been provided as part of annual training. Registered nurses interviewed were able to describe access to specialist services if required. Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities staff member continues to provide a comprehensive activities programme over five days each week. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned on the day were displayed on noticeboards around the facility. Resident files include a personalised activities assessment and plan. Residents are encouraged to join in activities that are appropriate and meaningful and residents are encouraged to participate in community activities. The service has a large van that is used for resident outings and a smaller van that is used for resident transport. Residents were observed participating in activities on the days of audit. The residents in the serviced apartment receiving rest home level care have the opportunity to attend either the serviced apartment programme or the rest home programme. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed were complimentary of the activities available.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans are reviewed and resident care is evaluated six monthly. This was evidenced in the three longer-term resident files reviewed. Six monthly reassessments include an InterRAI assessment. Written evaluations are completed in consultation with the multidisciplinary team including the GP and any other allied health professionals involved in the care of the resident.
Standard 1.4.2: Facility Specifications	FA	The service displays a current building warrant of fitness that expires on 1 April 2017.

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
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	An infection control team is representative of all staff. Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections. Individual short-term care plans are available for each type of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated two monthly as part of the infection control meeting and reported monthly to the quality meeting, where outcomes and actions are discussed. Annual reviews are documented. If there is an emergent issue, it is acted upon in a timely manner. The service has been monitoring urinary tract infections. Additional fluids have been introduced with a positive effect on the incidence of UTIs. There have been no outbreaks reported since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has restraint minimisation and safe practice policy in place. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. The service has no residents with enablers or restraint. Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed.

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 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	Electronic medication charts reviewed corresponded with the signing administration records for regular and ‘as required’ medications. One of three paper-based charts recorded allergies and two did not. Warfarin administration was documented in the sample of both electronic and paper-based medications charts. One medication administration chart did not always document the amount of warfarin administered.	1) Of a sample of three residents prescribed warfarin, two were paper-based; one was prescribed on the electronic chart and signed for on a paper-based system. This warfarin administration chart had three instances of the administrator not stating how much warfarin had been administered. 2) Two of three paper-based charts did not document allergies.	1) Ensure that all variable dose medication documentation includes the amount administered. 2) Ensure medication charts document allergies (or nil allergies).

				30 days
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	All five resident files reviewed had a care plan in place. The respite resident had an appropriate short-term care plan in place and one long-term care resident had an appropriate care plan in place. Pressure injury care was not provided for all residents requiring pressure injury prevention. On the day of audit, there were 19 wounds, including six residents with pressure injuries (eight pressure injuries - five x grade two and three x grade one). Eight of nineteen wounds had fully completed documentation. Short-term care plans were not in place for all wounds and acute conditions.	Wound care: 1a) Two residents had more than one wound recorded on each form, so that wounds were unable to be evaluated separately. 1b) Of the 19 wounds, four had not been evaluated/redressed within set timeframes, five did not state the size of wound/grade of pressure injury (one pressure injury with no grade), and two had an incomplete assessment. 1c) Short-term care plans were not in place for the wounds and/or information in the long-term care plan did not direct staff as to nursing care. Long-term care plans: 2a) Two residents with pressure injuries did not have interventions documented in the care plans to prevent further skin damage. 2b) One resident with mobility changes did not have the care plan updated to reflect changes and one resident's care plan did not reflect the high falls interventions needed. 3) Short term care plans were not in place for two residents with short-term conditions. 4) Two residents with pressure injuries and wounds did not have interventions implemented to prevent further injury or aid healing.	1) Ensure residents with wounds have fully completed wound care assessments and evaluations for each wound. Ensure that wounds are evaluated and re-dressed according to set timeframes 2) Ensure that long-term care plans document the care needed. 3) Ensure that short-term care plans are in place for all wounds and all acute changes in resident need. 4) Ensure that all required interventions are implemented to provide for resident care

				and safety. 30 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.