

Golden Pond Private Hospital 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 The DAA Group 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:	Golden Pond Private Hospital Limited
Premises audited:	Golden Pond Private Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 August 2016 End date: 18 August 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:	59

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

Golden Pond Private Hospital (Golden Pond) continues to provide hospital and rest home level care to a maximum of 60 residents. This unannounced surveillance audit was conducted against a sub-set of the relevant standards and the contract with the district health board. There have been no significant changes to the scope or size of the service since the previous audit in 2014.

The audit process included review of policy and procedures, the review of resident and staff files, observations and interviews with residents, management and staff. Relatives on site during the audit were unwilling to be interviewed and attempts to interview a general practitioner were unsuccessful. The residents interviewed, talked positively about their experiences with the service and expressed confidence in the quality and extent of care provided.

One of the two improvements required from the 2014 certification audit had been addressed. There is an ongoing requirement to conduct regular performance appraisals of all staff.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service demonstrates that it adheres to the principles and practices of open disclosure when dealing with unwanted events.

All verbal and written complaints received by the service in the past two years have been responded to and investigated in a timely and open manner. Resident said they knew how to raise a complaint and that they were entitled to support during the process. There had been no known complaints investigated by the office of the Health and Disability Commissioner. The system is fair and effective.

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.
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Golden Pond is maintaining its ethos and commitment to continual quality improvement. The quality and risk management systems meet the standard required. Any areas of concern in service delivery are being promptly identified with actions to remedy the problem initiated. Information and methods which monitor the quality of the services provided are consistently reviewed and improved upon.

All adverse events reviewed are reported and investigated. There had been no events requiring external notification.

Staff are well managed according to policy and good employer practices. New staff are recruited in ways that ensure their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new staff. Ongoing staff education is planned and coordinated to ensure that staff receive relevant and timely training on subjects related to older people. Training is occurring regularly through in-service education sessions, via self-directed learning and presentations by external experts. Staff competency assessments are occurring regularly.

There are sufficient numbers of clinical and auxiliary staff allocated on all shifts, seven days a week to meet the needs of residents requiring hospital and rest home level care. Registered nurses (RNs) are on site seven days a week and on call 24 hours a day.

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.		Standards applicable to this service fully attained.
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The service meets the contractual time frames for the assessment, care planning and evaluation of care. The service has implemented the electronic interRAI tool for assessment and reassessment, with the care planning based on the outcomes of the assessment process. When there are changes in the resident's needs, a short term care plan is implemented to reflect these changes. The care plan evaluations are conducted at least six monthly on all aspects of the care plan.

Residents are reviewed by a GP on admission to the service and at least three monthly, or more frequently to respond to any changing needs. The provision of services is provided to meet the individual needs of the residents. A team approach to care ensures continuity of services.

The service has a planned activities programme to meet the recreational needs of the residents. Residents are encouraged to maintain links with their family and the community.

A safe medicine administration system was observed during audit. The service has documented evidence that staff responsible for medicine management are assessed as competent to do so.

Residents' nutritional requirements are met by the service with likes, dislikes and special diets catered for. The menu has been reviewed by a dietitian.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness. There have been no significant changes to the building, plant or equipment and these are being well maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation uses best known processes for determining safe and appropriate restraint and enabler use. On the day of audit the restraint register was up to date with those residents who required interventions having these to maintain safety. The methods used for assessment, consent and approval, monitoring, evaluation and review meet all the requirements of the Restraint Minimisation and Safe Practice Standards.

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 surveillance programme is appropriate for the size and nature of the services provided. Monthly surveillance data and audits are recorded, collated and reported to management. There is additional monthly benchmarking with other aged care services.

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	16	0	1	0	0	0
Criteria	0	41	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service continues to effectively manage its complaints process and maintain the complaints register. Residents confirmed knowledge of the ways to lodge a complaint. Review of the complaints register and interview with the nurse manager revealed that each of the complaints received since the previous audit had been acknowledged and openly addressed, thoroughly investigated and resolved in a timely manner with all parties. The records show there was ongoing communication with the people involved and all issues have been resolved. One complaint involved the Nationwide Health and Disability Advocacy service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The organisation is adhering to the principles of open disclosure and the procedures within their policy. Review of information related to incident/accident reports and complaints received reveal the ways in which the organisation attends to the rights of residents and their families to know what has happened to them and to be fully informed. Evidence of notification to families and the GP was seen in accident/incident forms and in the residents' progress notes.</p> <p>There are no residents who currently require interpreter services. The clinical manager advised that family members have interpreted for residents in the past. Staff have developed systems for communicating with a resident who has lost the ability to talk.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>There have been no changes to the ownership or governance of the service for more than 25 years. On the day of audit there were 59 residents on site. Six of these were assessed as requiring rest home level care and 53 as requiring hospital care. One resident was under the age of 65 years (funded by ACC) and one was in receipt of palliative care.</p> <p>The organisation's vision, mission, values and annual goals are in the current business plan which is reviewed regularly with the owner.</p> <p>The nurse manager continues to meet with the owner weekly. The nurse manager has a current practising certificate with the Nursing Council of NZ and is maintaining her nursing portfolio and meeting the contractual requirements by attending on going education in clinical and management topics.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation is maintaining effective quality and risk management systems. Golden Pond has commenced benchmarking the frequency and type of accidents/incidents and infections with two other similar sized aged care providers. Quality improvements are documented for action and completion whenever a service deficit is identified via internal audit, or as a result of analysing quality data or feedback. There is evidence of 18 improvements to service delivery in 2015 and six, year to date, in 2016. Residents and family feedback is sought regularly via surveys and meetings.</p> <p>Policies and procedures are reviewed annually and updated as required to meet known best practice.</p> <p>All quality data continues to be analysed and discussed at monthly care meetings which is attended by a number of RNs from different shifts, caregivers, the health and safety officer and kitchen staff. Other staff are kept informed about quality matters through the sharing of quality/care meeting minutes and data. There is documented evidence of corrective actions on incident/accident reports, on the internal audit tools where a deficit or gap is identified, in the hazards register, and in complaints documentation.</p> <p>The organisation's annual business plan, quality and risk plan and associated emergency plans identify all actual and potential risk to the business, service delivery, staff and/or visitor's health and safety. Environmental risks are communicated to visitors, staff and residents as required through notices, or verbally, depending on the nature of the risk</p> <p>The service has been focusing on its adherence to health and safety legislation with the introduction of the amended Health and Safety at Work Act 2015. The service is maintaining a low rate of staff injury. At risk residents are identified through analysis of incident data (for example falls, infections, skin tears and other known factors such as confusion). Contingencies to prevent or minimise injury to 'at risk' residents is discussed at care meetings, and actions are agreed and initiated. The hazard register and risk management plan are being kept updated. A natural disaster topic, such as tsunami or earthquake, is nominated for study and contingency planning every month. Staff interviewed confirmed knowledge of and participation in quality</p>

		and risk management processes.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The adverse event reporting system was known by staff interviewed and is co-ordinated by the nurse manager. The event records showed that reporting occurs immediately and is investigated to determine cause and prevent or minimise recurrence. All people impacted by the adverse event are notified. The manager advised there had been no events requiring external notification.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Golden Pond continues to effectively manage its staff. The skills and knowledge required is documented in position descriptions and employment agreements. The nurse manager and a cross section of staff confirmed they understand their roles, delegated authority and responsibilities. Every job applicant is reference checked and police checked. Staff records contained evidence of curriculum vitae (CVs), educational achievements, and copies of current practising certificate.</p> <p>New staff are oriented to organisational systems, quality and risk, the Code of Rights, health and safety, resident care, privacy and confidentiality, restraint practices, infection prevention and control and emergency situations.</p> <p>Staff maintain knowledge and skills in emergency management, first aid certificates and competencies in medicine administration and attend regular training. The service supports all health care assistants (HCAs) to complete the Aged Care Education (ACE) programme.</p> <p>Although there is an improvement in the completion of performance reviews for care staff, only three of the 10 RNs have engaged in a performance appraisal in the past 12 months.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	FA	<p>Rosters sighted, and interviews with all levels of staff, residents and families confirmed that there is an appropriate number of staff on site at all times. RNs are available on site with more on call 24 hours a day seven days a week. Residents are satisfied with the responsiveness of staff.</p>

experienced service providers.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The service uses a prepacked robotic sachet system for the administration of medication. The sachets are checked for accuracy when they are delivered and at each medication administration. The medication records reviewed were dated, signed off and signatures can be verified with the specimen signature list. Photo-identification was observed on each record sighted. Allergies and sensitivities are documented on signing sheets. There is evidence that signing sheets are recorded appropriately and alert stickers are available. Signature specimen lists are in the front of each medication folder for the medical and nursing staff for verification if required.</p> <p>There are residents who self-administrator their medication, with appropriate competency assessments sighted for these residents.</p> <p>The staff responsible for medication management have all completed medication competencies and on-going education relating to medication management as verified on the education record spreadsheet reviewed.</p> <p>There are processes in place to rotate the stored medicines to ensure they do not expire. The control drugs are securely stored, with the controlled drug register meeting legislative requirements. The medication fridge temperature is recorded daily.</p> <p>The GP conducts medicine reconciliation when residents are admitted to the service and at least three monthly thereafter. Medicine file reviews showed that each medication was individually signed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The menu has been reviewed by a dietitian in 2016. Changes suggested by the dietitian have been implemented as part of the quality programme. On admission a nutritional assessment is performed by the RN and a copy is provided and retained by the kitchen staff. Any special dietary requirements or special diets are recorded and acknowledged by the kitchen staff when preparing the individual meals.</p> <p>The kitchen has areas designated for food preparation, plating/tray system serving areas, clean and dirty areas as required. Daily cleaning schedules are met by the staff in all areas of the food service, as was observed. Rubbish is stored appropriately and disposal processes are in place. Food monitoring of all the fridges and freezers occurs on a daily basis and the records reviewed show that temperatures are within the required range. The kitchen staff have food safety qualifications. The service is in the process of registering a food safety plan.</p>
<p>Standard 1.3.6: Service</p>	FA	<p>The care plans reviewed are based on the assessed needs of the resident. The assessment outcomes and interRAI assessment protocols are used to assist in the development and review of the care. There was</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>evidence in documentation reviewed of a resident whose falls risk assessment had changed from a low to medium risk. Changes to the care plans included regular checking of the resident and leaving the call bell accessible.</p> <p>The staff interviewed reported they were informed of any care plan changes at hand over and have relevant in-service education as required specific to any new interventions.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The residents are included in meaningful activities at the care facility. The residents were observed to be participating in meaningful activities both inside and out in the grounds of the service. The residents and families reported overall satisfaction with the level and variety of activities provided. Residents were observed to be going offsite with family/friends, with a number of community organisations providing activities at the service. There are planned activities and community connections that are suitable for the younger residents at the service.</p> <p>There is an activities coordinator Monday to Friday and staff assist with the planned and diversional activities over the weekend. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The activities staff reported that they gauge the response of residents during activities and modified the programme related to the response and interests. The activities are modified according to the capability and cognitive abilities of the residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The service uses the InterRAI re-assessment and related outcome scores to demonstrate how the resident is progressing towards meeting their goals. These occur at least six monthly or sooner if there are any changes. The RNs then update and print a new care plan every six months to reflect the needs of the residents. The service could also benefit from using the evaluation outcome drop box in the Momentum Healthcare care plan format.</p> <p>Residents' changing needs are clearly described in the care and support plans reviewed. Short term care and support plans are available and were sighted for wound care management, skin tears, pain management, changes in mobility, changes in food and fluid intake requirements, weight loss and skin cares.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	FA	<p>There is a current building of warrant of fitness. Plant and equipment is checked and maintained as required by legislation, regulations and standards. Hazard reporting/monitoring, reactive and preventative maintenance occurs. All external areas are safe. There have been no changes to the structure of the building since the previous audit.</p>

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	There is monthly surveillance of infections. Data is collected on a range of infections applicable to the aged care service. The data is also benchmarked on a monthly basis with two other aged care services. Infection reports are completed and reviewed individually by the infection control coordinator/clinical manager. The staff reported that infection information is provided at handover. Staff demonstrated knowledge of interventions required to reduce infections, with fluids also given and encouraged with the medication rounds.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is one resident who is using bedrails as a restraint and nine residents using enablers. Interview with two residents who use enablers confirmed that these were initiated at the resident's request, are voluntary and/or necessary for safe mobilisation. All restraint matters are discussed and reviewed at monthly care meetings.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The previous area requiring improvement has now been addressed. The assessment procedures have been amended and now identify all risks related to the type of restraint in use or risks related to the individual resident.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Review of 10 staff files confirmed that caregivers have regular (at least) annual performance appraisals. This was confirmed by the caregivers interviewed on the day of the audit. Seven of the 10 RNs are overdue a performance appraisal. The nurse manager stated that although each RN has been instructed to complete a self-appraisal and then arrange a time for formal review to occur, the RNs are not being proactive in arranging these.</p>	<p>Seven of the 10 RNs are overdue a performance appraisal. The previous corrective action is not yet resolved.</p>	<p>Ensure that all staff, including the RNs have regular performance appraisals.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.