# Lakewood Rest Home Limited - Lakewood Rest Home

## 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:** Lakewood Rest Home Limited

**Premises audited:** Lakewood Rest Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 22 September 2016 End date: 23 September 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:** 35

# 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

Lakewood rest home is certified to provide dementia level care for up to 36 residents. On the day of audit there were 35 residents. The service is privately owned and managed by a registered nurse manager. He is supported by a registered nurse, an administrator and care staff.

Families interviewed were complimentary of the care provided by staff. The service continues to implement a quality and risk management programme.

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

The audit has identified that no improvements are required.

## 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 Lakewood rest home strive to ensure that care is provided in a way that focuses on the individual, and residents' autonomy is valued. Information about the code of rights and services is easily accessible to residents and families. Care plans accommodate the choices of residents and/or their family/whānau. Open communication is practiced. Complaints and concerns have been managed.

## 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. |

Lakewood rest home is certified to provide dementia level care in a 36 bed facility. The management role is provided by the registered nurse owner, with support from a full time registered nurse and care staff. Quality activities are conducted to identify improvements in practice and service delivery. Health and safety policies are implemented to manage risk. Staff advised that there is an orientation programme that provides new staff with relevant information for safe work practice. A roster provides sufficient shifts to cover for the delivery of care and support to rest home residents.

## 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. |

The service provides an information booklet for residents/families at entry which includes information on the service philosophy, services provided and practices particular to the secure units.  Initial assessments are completed by a registered nurse, including InterRAI assessments.  The registered nurses complete care plans and evaluations within the required timeframes.

Care plans are based on the InterRAI outcomes and other assessments.  They are clearly written and caregivers report they are easy to follow.  Residents interviewed confirmed they were involved in the care planning and review process.  A 24-hour multidisciplinary care plan identifies a resident’s behaviours and activities or diversions that are successful.  The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident.  Individual activity plans are developed in consultation with resident/family.

Medicines are stored and managed appropriately in line with legislation and guidelines.  General practitioners review residents at least three monthly or more frequently if needed.  There is support provided by the community mental health team. All meals are cooked on site.  Resident’s individual food preferences, dislikes and dietary requirements are met.  Nutritional snacks are available over a 24-hour period.  There is dietitian review and audit of the menus.  All staff are trained in food safety and hygiene.

## 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 building has a current building warrant of fitness.  There is a planned maintenance schedule.  There is adequate space in the facilities for storage of mobility equipment.  Residents’ rooms, lounge areas and environment are suitable for residents requiring secure dementia care.  Outdoor areas are safe and secure and accessible for the residents.  There is adequate equipment for the safe delivery of care.  All equipment is well maintained.  All chemicals are stored safely throughout both facilities.  The staff maintain a tidy, clean environment.  There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

## 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. |

There is a restraint policy that includes the provision of a non-restraint environment. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register. There is currently one resident assessed as requiring restraint and no residents using enablers.

## 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. |

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 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 101 | 0 | 0 | 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](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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (three caregivers, one diversional therapist, supervisor and the registered nurse) confirm their familiarity with the Code. Interviews with four relatives confirm the services being provided are in line with the Code of rights. Code of rights and advocacy training has been provided in the past two years.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives.  All six files reviewed included signed informed consent forms and advanced directive instructions.  Staff are aware of advanced directives.  Admission agreements were sighted which were signed by the resident or nominated representative.  There is evidence of enduring power of attorney (EPOA) or ongoing attempts to establish an EPOA for each of the residents reviewed.  Interviews with staff and families state they have input and are given choices.  Care plans and 24-hour multidisciplinary care plans demonstrate resident choice as appropriate. |
| Standard 1.1.11: Advocacy And SupportService 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 families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the 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. The residents’ files include information on residents’ family/whānau and chosen social networks. An advocate attends the resident meetings.Relatives are provided with a copy of the Code and Nationwide Health and Disability Advocacy services pamphlets on entry. Discussions with relatives identify that the service provides opportunities for the family/EPOA to be involved in care decisions of residents. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | The resident information pack states that visiting can occur at any reasonable time. Interviews with relatives confirm that visiting can occur at any time. Family and friends 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 relatives verify that they are supported and encouraged to remain involved in the community. Lakewood staff support ongoing access to the community and entertainers are invited to perform at the facility.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | Complaints policy and procedures are in place. Relatives can lodge formal or informal complaints through verbal and written communication, resident/relatives’ meetings, and complaint forms. Information on the complaint’s forms and response letters includes the contact details for the Health and Disability Advocacy Service. Relatives stated they were familiar with the complaints procedure. There have been five complaints documented (both verbal and written) in 2016. The complaints register has been maintained. Each complaint reviewed has a follow-up plan documented, including the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. Advised that resident/relative meetings are an open forum for residents to air any concerns or issues.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The service provides information to residents that include the Code of rights, 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 relatives identify they are informed about the code of rights. The owner/manager and registered nurse provide an open-door policy for concerns or complaints.Resident meetings have been held providing the opportunity to raise concerns in a group setting. Advocacy pamphlets, which include contact details, are included in the information pack. 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 RespectConsumers 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. House rules and a code of conduct is signed by staff at commencement of employment. Church services are held. Contact details of spiritual/religious advisors are available to staff. Relatives interviewed confirm the service is respectful.Residents’ files include their cultural and/or spiritual values when identified by the resident and/or family. Discussions with residents confirm that they are able to choose to engage in activities and access community resources. Staff receive education and training on abuse and neglect.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 Māori heath plan and an individual’s values and beliefs policy, which includes cultural safety and awareness. Residents who identify as Māori have this recorded in their long-term care plan. 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 for staff. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers 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 indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Family involvement is encouraged (eg, invitations to residents’ meetings and facility functions). The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the registered nurse. |
| Standard 1.1.7: DiscriminationConsumers 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 Lakewood code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues which are provided to staff on employment. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with the care staff. Interviews with staff confirm their understanding of professional boundaries.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The quality management policy 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 ongoing in-service training. The 2016 relative satisfaction survey reflects high levels of satisfaction with the care that is provided. The administration person and manager are responsible for coordinating the internal audit programme. Policies and procedures have been reviewed. These are available in hard copy. Staff meetings and resident’s meetings have been held. Relatives interviewed spoke very positively about the care and support provided by the caregivers and registered nurse. Staff had a sound understanding of principles of dementia care and state that they are well supported by the manager and registered nurse. There are implemented competencies for caregivers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies are in place relating to open disclosure. Relatives interviewed state 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, as evidenced in the sample of incident reports reviewed. A quarterly newsletter is provided for relatives.Relatives/EPOAs 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.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lakewood rest home is owned and managed by a registered nurse. The home provides dementia level care to up to 36 residents. On the day of audit there were 35 residents, including one respite resident. There were 30 residents under the age related contract, one respite resident and four residents under the age of 65 on close-in-age aged care contracts. The manager has owned Lakewood for the past 13 years. The manager has qualifications in education and mental health. A full time registered nurse has been with the service for just over one year. The service has a business plan, and a quality programme. An annual quality plan is in place and the business/quality programme has been reviewed for 2015.The manager has completed at least eight hours of professional development relating 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 a manager, the supervisor (previously enrolled nurse) is in charge with support from the registered nurse, care staff and the administration person/owner.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality programme includes the service philosophy, general objectives and lists the quality activities. An annual quality plan for 2016 has been developed. An internal audit schedule is being completed for 2016. Corrective actions have been developed and developed where compliance is less than expected. This is evidenced in the meeting minutes reviewed for staff, quality assurance and resident meetings. Quality meetings evidence discussion of quality activities. Resident meetings are held with follow-up of issues and discussions are completed. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. A relative survey was last conducted in August 2016 with respondents advising that they are overall very satisfied with the care that residents receive. The service collects information on resident incidents and accidents as well as staff incidents/accidents. The service has a health and safety management system and hazard registers are documented for each area of service. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures. There are procedures to guide staff in managing clinical and non-clinical emergencies. Falls prevention strategies are implemented.  |
| 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. Accidents and near misses are investigated by the registered nurse and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings. A sample of incident/accident forms reviewed for July and August had been commenced by either the caregivers or the registered nurse. Progress notes reviewed for a sample of residents’ evidence that incidents and accidents have been reported. Follow-up by a registered nurse is evident in all of the sample of resident incident forms reviewed. A current pressure injury, and previous pressure injuries, have been reported. The manager was aware of the requirement to notify relevant authorities in relation to essential notifications. The healing grade-3 pressure injury was reported to the MOH via a section 31 form on the day of audit.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are human resource management policies in place which includes recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. The human resources policies also include orientation, staff training and development. Six staff files were reviewed (one registered nurse, three caregivers, one cook and one diversional therapist) and evidence that reference checks are completed before employment is offered. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. Staff files reviewed had completed orientation documentation. Staff were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.Discussion with the registered nurse and staff and records reviewed confirms that an in-service training programme has been provided. The in-service calendar for 2016 is being implemented. The service has engaged the Careerforce training programme for caregivers. The registered nurses are able to access external training provided by the DHB. Both the manager and registered nurse have completed the InterRAI training programme and have achieved competency. The service has nineteen care staff including an enrolled nurse and a diversional therapist. Sixteen staff have completed dementia unit standards. The three caregivers, who have not completed the unit standards, have commenced employment in the past 12 months.  |
| 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 staffing policy includes staff rationale and skill mix. The manager (registered nurse) is on site Monday to Friday. The registered nurse also works full time. There is a minimum of two caregivers on duty at any one time and either the registered nurse or the manager on call. There is at least one staff member on each duty with a first aid certificate. Staff and relatives interviewed confirmed that there are sufficient staff rostered on for the provision of care for 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 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. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. File entries are legible, dated and signed by the relevant caregiver or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts and progress notes are maintained separately. |
| 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 | There is a policy for resident admissions that includes responsibilities, assessment processes and timeframes. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the level of care requirements. All six resident files reviewed had an NASC assessment for secure dementia care. The service has an ‘information for residents/families’ at entry. The pack includes all relevant aspects of service delivery (such as those associated with a secure dementia unit) and residents and/or family/whānau are provided with associated information such as the Code of consumer rights, complaints information, advocacy, and admission agreement. Four family members interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Admission agreements are signed and in place for six resident files reviewed. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and ‘the yellow envelope’ is used. The RNs report that they include copies of all the required information in the envelope. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for all aspects of medication management. All medications are checked by an RN on delivery against the medication and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and caregivers, who are responsible for the administering of medications, have completed annual medication competencies and annual medication education.The medication room was clean and well organised. All medications were in date and stored appropriately. The medication fridge had temperatures recorded daily and these were within acceptable ranges. Medication administration practice complies with the medication management policy for the medication round observed. Ten medication charts were reviewed. Photo identification and allergy status was on all charts. All medication charts had been reviewed by the GP at least three monthly. All resident medication administration signing sheets corresponded with the medication chart. There were no self-medicating residents as Lakewood is a secure dementia unit. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | There is a small functional kitchen at Lakewood. All food is cooked on site. The service employs two cooks who are supported by care staff. Kitchen staff have completed safe food handling certificates. A cleaning schedule is maintained and the kitchen was observed to be very clean and well kept. There is a large walk-in chiller in the kitchen and a freezer in a storage area. The kitchen has a well-stocked pantry, electric cooker, electric oven and microwave. The service has a four-week winter and summer menu and documented annual menu reviews by a dietitian. Resident files reviewed show evidence of nutritional assessments being conducted on admission. Dietary information is documented in the care plan and verbally handed over to kitchen staff. Resident weights are monitored monthly and the service is able to utilise a dietitian for weight loss should this be required. Residents displaying weight loss are reviewed and monitored by the general practitioner and the dietitian as needed. The daily menu is posted in the dining room. Fridge and freezer temperatures are monitored daily and recorded monthly. Food in the fridge and freezers is covered and dated. Drinks and snacks are available at all times for residents. |
| 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 | The reason for declining service entry to potential residents is recorded should this occur and communicated to the potential resident (as appropriate)/family, the referring agency would be advised when a potential resident is declined access to the service.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The information gathered on admission is used to develop care plans, and supports the promotion of best care for the residents. Risk assessment tools are reviewed at least six monthly. InterRAI assessments have been completed for all resident files reviewed and have been updated at least six monthly. The outcomes of InterRAI assessments and formal paper based risk assessments were reflected in the long-term care plans reviewed. The diversional therapist completes a comprehensive social assessment and comprehensive activity care plan in consultation with the resident/family. Additional assessments such as behavioural assessments, behaviour monitoring and dementia orientated activities assessments were documented well in files reviewed. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The resident files reviewed were resident focused, integrated, and promoted continuity of service delivery. Five of six resident files included a nursing long-term care plan (one was a respite resident). Care plans were comprehensive and updates were documented as needed. The respite resident had a care plan in place that ensured the resident needs were addressed. The six care plans reviewed all documented interventions to manage any behaviour that challenges, including diversionary interventions and management of outbursts as needed.Staff interviewed stated they have free access to the resident files. This was also observed on the days of audit.Family members interviewed agreed that they had been involved in the care planning development and review process. Short-term care plans were in place for acute and short-term conditions and had been evaluated on a regular basis. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | All resident files reviewed had care plans in place. When a resident’s condition changes, the RN initiates a GP visit or nursing specialist referral. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Continence products are available and resident files include a three-day 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 by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.Wound care plans were paper based and included an assessment, wound management and evaluation forms. Seven wound care plans were reviewed including one healing grade-three pressure injury, one skin tear, one swollen hand, three stoma sites for regular review and one risk for a pressure injury for regular review.Care staff interviewed were able to describe management of individual residents and their care. Care staff were observed to be very supportive to residents on the day of audit.Monitoring charts were in use and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, turning charts and behaviour monitoring as required.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 service employs a qualified diversional therapist five days a week and the service is in the process of employing another activities staff member to assist (caregivers assist currently). An activities programme is provided for seven days a week. There is a monthly activity planner which is designed with input from the resident (and family as needed). The programme reflects the resident’s interests and abilities and they have choice in their level of participation. Activities include (but are not limited to) exercises, newspaper reading, floor games, entertainment, walks, quizzes, and reminiscing, seasonal celebrations, arts and crafts, baking, and knitting. Specific activities are provided for individual residents reflecting their interests and need for diversional therapies. One-to-one support is provided in situations where residents are unable to participate in group activities. Activities for the younger residents are provided as needed and currently include walking, community trips and assisting with household tasks.Residents have an activities and social profile completed on admission, an activities plan which includes resident goals. Progress notes are maintained on a weekly basis. Activities plans include a 24-hour activity plan for each of the residents. Attendance records are kept. Four family interviewed spoke positively of the programme. Activities are regularly evaluated with residents and family to ensure that the activity programme is appropriate for the residents who currently reside at Lakewood. The activities coordinators stated at interview that residents are asked frequently to give verbal feedback and asked for suggestions. Resident files reviewed identified that the individual activity plan is reviewed at the same time as the care plan review occurs.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The resident files reviewed included six monthly reviews and were updated when needs changed. Clinical reviews were documented in the multi-disciplinary review and documented progress towards stated goals. Progress notes were completed and reflected response to interventions and treatments. Changes to care were documented. Documentation of GP visits evidenced that reviews were occurring at least three monthly. Short-term care plans were in use for short-term issues |
| 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 | The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and/or their family/whānau are involved as appropriate when referral to another service occurs. The clinical supervisor and registered nurse interviewed described the referral process should they require assistance from specialist practitioners. The review of resident folders included evidence of recent referrals. The GP stated that referrals were timely and appropriate and that the current residents were appropriately placed. |
| 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 | There are policies in place in for waste management, waste disposal for general waste and medical waste management. There is an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals. Chemicals are stored in a locked storage cupboard in the laundry until required. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Staff have been provided with education in chemical safety as part of the annual training plan. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness which expires on 1 June 2017. There is an approved evacuation plan dated 9 June 2005 and fire drills are completed six monthly. Maintenance is conducted as required. Medical equipment and scales have been calibrated by an authorised technician. Hot water temperatures are recorded and are consistently recorded between 43 and 45 degrees Celsius. The service is well maintained with a home-like décor and furnishings. There is a large communal lounge, a quiet lounge, dining area, and communal bathroom and toilet facilities. There are small seating nooks available for residents and visitors. The corridors have handrails in place. There is easy access to the outdoors. Outdoor ramps have handrails. The unit has a secure garden. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 | A number of residents have shared ensuite facilities. The number of communal toilets and showers provided is adequate. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Toilets and showers have signage and privacy locks. Family interviewed state their resident’s privacy and dignity is maintained while attending to their personal cares and hygiene and this was observed on the day of audit.Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs. |
| 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 | The rooms are of sufficient size to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient space to allow cares to take place. The bedrooms are personalised.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge and dining room, a smaller lounge and dining area and a library/quiet room in the facility. The dining rooms are spacious and located adjacent to the kitchen area. Food is plated and served directly to residents in the dining room at mealtimes. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Lakewood rest home has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Staff attend infection control education and there is appropriate protective clothing available. Care staff complete cleaning/laundry tasks. Manufacturer’s data safety charts are available. Families interviewed reported satisfaction with the laundry service and cleanliness of the room/facility. Laundry audits are conducted as part of 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 | Appropriate training, information, and equipment for responding to emergencies is provided. Fire evacuations are held six monthly.There is a civil defence and emergency plan in place. The civil defence kit is readily accessible and includes torches, batteries, lamps, Hi-Viz vests and radios. The facility is well prepared for civil emergencies and has emergency lighting, a generator, stored water and access to an adjacent artesian well, gas stove, gas heater and a gas BBQ for alternative heating and cooking. Emergency food supplies, sufficient for three days, are kept in the kitchen. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas.There are emergency management plans in place to ensure health, civil defence and other emergencies are included. |
| 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 | All communal areas and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Family interviewed state the environment is warm and comfortable.  |
| Standard 3.1: Infection control managementThere 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 | Lakewood rest home has an established infection control 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 quality management system. The registered nurse is the designated infection control coordinator with support from the manager and staff, as the infection control team. Staff meeting minutes are available for staff. Infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and staff have good external support from the local laboratory infection control team and IC nurse specialist at the DHB. 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 proceduresDocumented 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 | The service has infection control programme policies and procedures that reflect best practice. These infection control policies and procedures appropriate 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 have been reviewed and updated.  |
| 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 ongoing education of staff and residents. Formal infection control education for staff has occurred, provided by an external infection control specialist. The infection control coordinator has completed ongoing 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 relatives and visitors that is appropriate to their needs. Infection related information is documented in resident records.  |
| Standard 3.5: SurveillanceSurveillance 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 the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection and is analysed. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary in the electronic database. This data is monitored and evaluated monthly and compared month by month. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisationServices 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 minimised. There were no residents with an enabler and one resident with a restraint in the form of a chair and table. Enabler use is voluntary. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP) and challenging behaviour management and de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.  |
| Standard 2.2.1: Restraint approval and processesServices 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 manager (registered nurse) is the facility restraint coordinator. The policy and job description include clear responsibilities and accountabilities. Any resident with a restraint in use is required to have an assessment and consent form and regular monitoring documented. Care staff have been provided with restraint minimisation and safe practice education.  |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Either the manager or the registered nurse undertakes the assessment for restraint, in partnership with the resident’s family. The manager is the restraint coordinator. Restraint assessments are based on information in the care plan, a detailed restraint assessment form and on observations of the staff. There was a restraint assessment tool completed for the one resident file reviewed for a resident requiring a chair with table attached. The chair with table is only used when the resident is at risk of falling from being tired from constant wandering. The care plan was up-to-date and included the risks and interventions associated with restraint use. Ongoing consultation with the next of kin was also identified. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. The assessment and care plan identified specific interventions or strategies to try (as appropriate) before restraint is used.The one resident file reviewed for the resident with the chair with attached table included specific interventions and strategies considered before use of restraint. The care plan reviewed identified observations, monitoring and next of kin involvement. Restraint use is reviewed through the three monthly GP assessment, six monthly care plan evaluations, restraint review meetings and staff meetings. A restraint register is in place, which has been completed for the one resident requiring restraint. |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation occurs three monthly as part of the ongoing reassessment of any residents on the restraint register, and as part of their care plan review. The family is included as part of the review. Evaluation timeframes are determined by risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The use of restraint is documented as reviewed and discussed at staff meetings and at quality meetings. Discussion with staff evidences that the service actively reviews all restraint with attempts to minimise its use wherever possible. |

# 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.

|  |
| --- |
| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

|  |
| --- |
| No data to display |

End of the report.