# Springlands Senior Living Limited - Springlands Lifestyle Village

## 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:** Springlands Senior Living Limited

**Premises audited:** Springlands Lifestyle Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 7 November 2016 End date: 8 November 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 |
|  | 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

Springlands Lifestyle Village provides rest home and hospital level care for up to 56 residents. There are also 20 serviced apartments approved to provide rest home level care.

This certification audit was conducted against the relevant 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 residents and staff files, observations and interviews with residents, family members, staff and management.

The village manager has been in the position for six years. She has a New Zealand Diploma in Management and is supported by a clinical nurse manager who has been in the role for four years and an experienced hospital charge nurse.
This audit identified improvements required relating to reporting pressure injuries as incidents and aspects of care interventions.

The service has exceeded the required standard around the food service, health and safety and restraint minimisation.

## 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. |

Springlands provides a safe and culturally appropriate service for the residents. Policies are implemented to support residents’ rights. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

## Organisational management

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

The Springlands manager reports to the managing director who in turn reports to the board of directors. The current business plan is goal focussed. Springlands has an implemented quality and risk management system that supports the provision of clinical care and support and generates improvements. Key components of the quality management system link to a number of meetings including quality meetings.
An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings.
There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support. The implemented facility staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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

The clinical nurse manager takes primary responsibility for managing entry to the service with assistance from the hospital coordinator and the registered nurses. Comprehensive service information is available. 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 healthcare assistants report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. 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. Meals are prepared and cooked on site under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were very complimentary about the food service.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building has a current warrant of fitness and emergency evacuation plan. All rooms are single, personalised and have ensuite facilities. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activities. The dining and lounge seating placement encourages social interaction. Other outdoor areas are safe and accessible for rest home and hospital residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely and the laundry is well equipped. The cleaning service maintains a tidy, clean environment.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | All standards applicable to this service fully attained with some standards exceeded. |

The service has comprehensive restraint minimisation policies. The service currently has no residents using restraint and one resident with an enabler. Enabler use is voluntary. The service has actively minimised the use of restraint resulting in a significant drop in restraint use.

## Infection prevention and control

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

The infection control (IC) team is led by the clinical nurse manager who is supported by the infection control team that incorporates representation from all areas of the service. The infection control policy identifies clearly the roles of the IC nurse and supporting team.
The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the IC nurse, management and through infection control meetings. Staff are informed about IC practises and reporting through staff meetings, training and information posted up on staff noticeboards.
The service has developed strong links with Canterbury Southern Community Laboraties and the public health service, with a member of this service providing training to staff and advice as needed.

## 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** | 1 | 43 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 3 | 89 | 0 | 2 | 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 | The service has a range of policies and procedures to ensure that resident’s rights are protected. All staff interviewed (five healthcare assistants (one from the rest home, three who work throughout the facility and one who works in the apartments), three registered nurses (the hospital charge nurse and two rest home registered nurses) and the diversional therapist) were aware of consumers’ rights and were able to describe how they incorporated consumer rights within their service delivery. Ten residents (seven rest home including three in apartments and three hospital) and five family members (two rest home and three hospital) interviewed spoke highly of respect for all aspects of the Code. |
| 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 | Informed consent processes are discussed with residents and families on admission. The resident or their enduring power of attorney (EPOA) signs for written general consents. Cardiopulmonary resuscitation status is evident in the eight resident files reviewed (five rest home and three hospital). Registered nurses and healthcare assistants interviewed confirmed verbal consent is obtained when delivering care. Family members confirmed they were involved in decisions that affect their relative’s lives. All resident files contained a signed admission agreement.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information about accessing advocacy services is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Interviews with staff, residents and family members confirmed that they are aware of advocacy and how to access an advocate.  |
| 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 | Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. On interview, all residents and family members confirmed this.Discussion with family members stated that they are encouraged to be involved with the service and care.Discussion with staff, residents and family members confirmed that residents are supported and encouraged to remain involved in the community and external groups such as church, and community networks.  |
| 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 complaints process. There is a complaints form available. Information about complaints is provided on admission. There is a complaints register. Verbal and written complaints are documented.The service documents all complaints including those at a very low level. The complaints reviewed in detail (seven of the 25 complaints for 2016 year to date) had documented acknowledgement, investigation, timelines, corrective actions when required and resolutions. Results are fed back to complainants. Discussions with residents and family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Complaints are an agenda item for the weekly management meeting, quality meetings and staff meetings.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | There are posters of the Code of Rights on display in the foyer of the facility and leaflets from the Health and Disability Service and Advocacy service are also available in the foyer of the facility. On entry to the service, residents receive an information pack that includes a code of rights information and a service agreement. All staff interviewed stated that they take time to explain the rights to residents and their family members. Residents and family members confirmed that they had received information about their rights on entry to the service. |
| 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 | All staff sign ‘house rules’ on employment which includes respect for residents and the service vision includes respect and independence.Staff were observed respecting residents’ privacy, for example, knocking on doors and referring to residents by their preferred names. All residents and family members interviewed indicated staff were highly respectful and maintained resident’s privacy. Resident preferences are identified during the admission and care-planning processes that occur with family involvement.There is a preventing abuse and neglect policy and the topic is covered at orientation. Staff interviewed were able to discuss what constitutes abuse and neglect and the importance of recognition and reporting any issues.  |
| 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 | The service has established cultural policies to help meet the cultural needs of the residents. There is a Māori health plan in place. Discussions with the clinical nurse manager, registered nurses and healthcare assistants confirm that they are aware of the need to respond to cultural differences. On interview, all staff were able to identify how to obtain support so that they could respond appropriately. The service has three residents in the rest home that identify as Māori. The care plans documented the resident’s Iwi, and the involvement of whānau on a regular basis. Māori residents were observed enjoying kina and two interviewed stated the service goes to efforts to allow them to enjoy cultural kai and activities.The service is able to access Māori advisors and local Iwi advocacy services through the DHB.  |
| 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 | All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Care plans sampled documented individual needs including cultural and spiritual needs. There are regular church services with rotating denominations and interdenominational services provided.Family are involved in assessment and the care planning processes. Information gathered during assessment including residents cultural beliefs, are included in the care plan.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The service has an abuse and neglect policy which states that it will not be tolerated under any circumstances. Elderly abuse prevention training occurs at orientation and on a two yearly basis. The RNs supervise staff to ensure professional practice is maintained in the service. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The service’s policies are comprehensive; they guide practice that aligns with the Health and Disability Services Standards. There is a quality and risk framework and programme that is being implemented that includes performance monitoring and benchmarking with ongoing evidence of actions to reduce adverse events and infections. The clinical nurse manager and village manager have been instrumental in signing a memorandum of understanding with Canterbury DHB for registered nurses PDRP with all registered nurses enrolled. One registered nurse is supported with postgraduate study, with a goal to becoming a nurse practitioner.Careerforce for healthcare assistants is well implemented. All cleaning staff have completed a Careerforce qualification.The resident/relative survey in 2015 demonstrated a high level of satisfaction. Corrective action plans around areas identified from surveys for improvement mean that no areas for improvement continue from previous surveys (link CI 1.3.13.1). A comprehensive internal in-service training programme is being implemented.A staff wellness and support programme that includes return to work interviews and the availability of counselling and support has been well received by staff. Following an outbreak in August 2016 the service introduced a formal debriefing process to identify learning’s and future improvements for any future outbreak. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | On admission, all residents are provided with an information pack, which gives a comprehensive range of information regarding the scope of service provided to the resident and their family/whānau. Regular contact is maintained with family including if an incident or care/health issue arises. This was evidenced in 12 incident forms reviewed from both the rest home and hospital wings and the apartments.Family members interviewed stated they were well informed and involved when needed in residents care.There are regular residents’ meetings where any issues or concerns to residents are able to be discussed. The clinical nurse manager/RN contacts family members by phone and/or emails monthly. There are informative newsletters to residents and families three monthly. The service has policies and procedures available to enable access to DHB interpreter services and residents (and family/whānau), are provided with this information in resident information packs. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Springlands Retirement Village provides rest home and hospital (medical and geriatric) level care for up to 56 residents and also up to 20 serviced apartments approved as being able to provide rest home care. All rooms in the hospital and rest home wings are dual-purpose. Eleven of the studio units in the hospital and rest home wings are under license to occupy agreements (all are occupied by rest home level residents). On the day of the audit there were a total of 59 residents; 43 rest home including five residents in the apartments, two residents on short-term respite and one resident on a younger persons with disability contract and 16 hospital residents (all on the aged related care contract). There is a retirement village attached as part of the complex with overall management of the site provided by the village manager. The service is overseen by a board of directors that includes a managing director to who the village manager, and provides comprehensive monthly reports. The village manager has been in the position for six years. She has a New Zealand Diploma in Management. A clinical nurse manager is employed to oversee the running of the rest home and hospital. The clinical nurse manager has been in the role for four years and has previous management experience; she has completed a master’s degree in nursing and is a Careerforce assessor.There is a business plan and risk management plan that documents the mission, philosophy and goals of the business for the current year.The village manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. |
| 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 | During a temporary absence, the clinical nurse manager covers the village manager’s role. |
| 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 service has a comprehensive suite of policies that have been developed and are kept updated and current by an external contractor. The quality management system includes a comprehensive audit schedule. The village manager and clinical nurse manager manage the quality system jointly.There are regular meetings that include; two monthly staff meetings, weekly management meetings, monthly quality meetings, three monthly health and safety and infection control meetings and bi-monthly staff meetings and bi-monthly clinical meetings. Audits are undertaken according to the audit schedule and reported back to meetings.Three monthly audits and follow-up were specifically reviewed. All audits sampled (all for 2016) had an action plan where needed and all documented follow-up at staff and management meetings. Audit outcomes are emailed to all RNs individually and signed off by the clinical nurse manager. There is evidence that audit outcomes are used to improve services. Incidents and accidents and infections are recorded, collated and benchmarked electronically. Comprehensive reports are discussed in appropriate degrees of detail at relevant meetings.There is implemented risk management, and health and safety policies and procedures and systems in place, including accident and hazard management. Improvements related to changes resulting from the legislative changes, have resulted in the service exceeding the required standard.Falls prevention strategies such as physiotherapy reviews and individualised planning are used. |
| 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.  | PA Low | The service collects a wide range of data relating to incidents and accidents. The reporting system is integrated into the quality risk management system. All incident and accident forms are scanned with originals retained in the resident file.Once incidents and accidents are reported, the immediate actions taken are documented on electronic incident forms by the registered nurse. The incidents forms/database are then reviewed and investigated by the nurse manager or RN who monitor issues. If risks are identified these are also processed as hazards. The information is reviewed, collated and graphs produced. These graphs are posted up on the noticeboard in the nurse station(s). Not all pressure injuries had an incident form completed.The information is also reported to the facility meetings and in the monthly report to the managing director.Twelve incident forms were viewed from September. All had appropriate clinical review and implemented actions and review by the clinical manager documented. The village manager and nurse manager were aware of requirements around essential notifications. Four section 31 notifications had been completed for fractures in 2016, one for a fall resulting in a minor head injury and one was made during the audit for a grade 3 externally acquired pressure injury. Public health were promptly notified of a norovirus outbreak in August 2016. |
| 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 | Nine staff files were reviewed for this audit (the clinical nurse manager, the hospital charge nurse, one other registered nurse, two healthcare assistants, one cleaner, the diversional therapist, the kitchen manager and the maintenance person). All staff files documented a relevant job description and employment contracts and all had a documented orientation. The two RNs had an appraisal using the DHB scope of practice process and document PDRP. The clinical nurse manager is an active PDRP assessor for the DHB and has achieved senior portfolio level and the charge nurse has achieved proficient level. Four of the other seven registered nurses have portfolios. Annual appraisals were also in place for the remainder of the staff files sampled.Current practicing certificates are maintained for all registered staff and contractors. There is a comprehensive orientation programme relevant to staff roles and this was completed in all files sampled. Postgraduate education is encouraged. There are three registered Careerforce assessors. All cleaners have recently completed a Careerforce qualification. The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance recorded at sessions kept. Each session includes an attendance sheet and training content. Role relevant competencies are completed and recorded in a register. Postgraduate study is offered to all registered nurses and one nurse is currently undertaking a nurse practitioner pathway. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. All staff, residents, family members and the GP reported that staffing levels and the skill mix was appropriate and safe. The service operates over two floors. The top floor contains the apartments with five rest home residents currently residing there. There is a healthcare assistant designated to this area from 7.00 am to 1.30 pm and 3.00 pm to 9.30 pm. At other times needs are met by rest home and/or hospital staff.The hospital wing has 23 rooms. Six are currently occupied by rest home level residents. A registered nurse is based in this wing 24 hours per day (this is the hospital charge nurse during the day, during the week). The rest home is on the same level as the hospital and there is a registered nurse on duty in the rest home (which has all rest home residents) between 7.00 am until 10.00 pm seven days per week. This RN also covers the apartments on the floor above. All eight residents interviewed felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that there are registered nurses on duty at all times, and that at least one staff member on duty will hold a current first aid qualification. In addition the clinical nurse manager works 40 hours per week. She and the hospital charge nurse share clinical on call duties. The village manager is available on call for non-clinical issues if required. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All resident files are hard copy. The information collected on admission is of sufficient detail to identify, manage and track resident records for the service. Resident’s files are integrated.Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are stored securely and protected from unauthorised access by being held at the nurses’ station in a secured room. Old files are individually archived and locked in a secure area for 10 years.Resident records are up-to-date and reflect residents’ current overall health and care status. Records can be accessed only by relevant personnel.Entries are legible, dated and signed by the relevant caregiver or nurse including designation. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager, clinical nurse manager and/or RN. The admission agreement form in use aligns with the requirements of the ARC contract.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Residents’ medicines are stored securely in the dispensary room in rest home and hospital wings. For residents living in studios or apartments assessed as rest home level care, their medications are stored in the rest home area. Medication administration practice complies with the medication management policy for the medication rounds sighted. The service uses an electronic medication management system. There was evidence of three monthly reviews by the GP. Registered nurses and healthcare assistants administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a blister packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. There were three residents self-administering medication on the day of audit. All three residents had been assessed by a GP as competent to self-administer medications and competency was reviewed three monthly. Each resident had a locked drawer in their room for storage of medications (sighted). There were no standing orders.  |
| 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 | All meals are prepared and cooked on site at Springlands Lifestyle Village. There is a four-weekly seasonal menu which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. This exceeds the required standard. Pureed and gluten free diets and diabetic desserts are provided. Cultural and religious food preferences are met. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures and food temperatures prior to the food being served to the residents at Springlands Lifestyle Village, are recorded. All food services staff have completed or are enrolled in training in food safety and hygiene and chemical safety.  |
| 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 service has an accepting/declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information was gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six monthly or when there was a change to a resident’s health condition. The InterRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Care plans sampled were developed on the basis of these assessments. Eight of ten registered nurses are InterRAI trained.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed described the support required to meet the resident’s goals and needs and identified allied health involvement under a comprehensive range of template headings. The InterRAI assessment process informs the development of the resident’s care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Registered nurses (RNs) and heathcare assistant (HCAs), follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse or wound care specialist nurse). If external medical advice is required, this is actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management plans were not fully completed for all wounds. On the day of audit there were eleven wounds. In the hospital, five skin tears, one stage-3 pressure injury and one haematoma were being treated. In the rest home, one leg ulcer, one stage 2 pressure injury and one skin tear and abrasion were being treated. All wounds had been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service. Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. Care plan interventions demonstrate interventions to meet residents’ needs. Progress notes are written on each shift. However, not all concerns documented in progress notes evidenced follow-up by a registered nurse. There was evidence of pressure injury prevention interventions, such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.  |
| 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 activities programme at Springlands Lifestyle Village meets the recreational needs of the residents and reflects normal patterns of life. A qualified diversional therapist (DT) is employed full time Monday to Friday and coordinates the activities programme for the hospital and rest home. A part-time activity assistant works two days a week in the hospital wing. The weekend programme is delivered by care staff and volunteers. There is evidence that the residents have input into review of the programme via the resident survey and this feedback is considered in the development of the resident’s activity programme. The activity programme is developed monthly. A copy of weekly activity programme (including the weekly menu) is delivered to each resident’s roomAn activity profile is completed on admission in consultation with the resident/family (as appropriate). The activities documentation in the resident files sampled reflected the specific requirements of each resident. Residents interviewed evidenced that the activity programme had a focus on maintaining independence and reducing boredom and commented that a yoga instructor assists with the delivery of the exercise programme.In resident files sampled diversional therapy plans were evidenced to be evaluated as part of the six monthly care plan evaluation. Activity participation was documented on attendance sheets and evaluation. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six monthly or earlier if there was a change in health status. There was at least a three monthly review by the GP. Reassessments have been completed using InterRAI LTCF for all residents who have had a significant change in health status. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| 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 medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident’s condition had changed and the resident was reassessed.  |
| 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 implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were all stored safely throughout the facility. Safety datasheets are available. |
| 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 facility has a current building warrant of fitness that expires 19 April 2017. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. All electrical equipment has been tested and medical equipment calibrated in April 2016. The physical environment allows easy access/movement for the residents and promotes independence for residents with mobility aids. There are communal dining and lounge areas and smaller seating areas to allow for privacy or quiet reflection in the hospital and rest home. There is a maintenance person who carries out daily maintenance requests and records corrective actions in the maintenance book. There are monthly internal building and external building maintenance schedules in place. Water temperature monitoring of different rooms is carried out each month (sighted) and complies with regulations. The grounds are tidy, well maintained and able to be accessed safely. There are outdoor ramps with handrails, outdoor seating, shaded areas and raised garden beds. There is a designated outdoor smoking area.  |
| 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 | All rooms in the rest home and hospital have ensuite facilities and all apartments have their own bathroom. There are communal toilets located close to communal lounges and dining areas. Visitor’s toilets are located in each unit. All residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares.  |
| 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 | All resident’s rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.  |
| 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 are dining rooms in the hospital, rest home and apartment areas. The main dining room in the rest home is adjacent to the kitchen area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit. Residents interviewed report that they can move freely around the facility and staff assist them if required.  |
| 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 | There are dedicated cleaning staff. The cleaners’ trolleys are well equipped and all chemical bottles were labelled. Protective wear including plastic aprons, gloves and goggles are available in the two sluice rooms and laundry. Staff observed on the day of audit were wearing correct protective clothing when carrying out their duties. The laundry operates daily and launders the bed linen, towels and personal clothing. The laundry has a clean/dirty flow. The chemical provider monitors the effectiveness of laundry processes. Residents expressed satisfaction with cleaning and laundry services and that the staff take great care of their clothing. All housekeeping staff have attained an NZQA level 2 certificate in cleaning and are enrolled to complete level 3 via careerforce. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. The facility is well prepared for civil emergencies and has civil defence kits (readily accessible) that are checked monthly. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, torches, batteries and radio. The staff interviewed were able to describe the emergency management plan and how to implement this. Fire training and security situations are part of orientation of new staff. A minimum of one person trained in first aid is available at all times. There are call bells in the residents’ rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity. |
| 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 | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.  |
| 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 | The infection control team is led by the clinical nurse manager who is supported by the infection control team which includes representatives from each area of the service. The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the IC nurse, management and through two monthly staff meetings. The service has developed strong links with the public health service, with a member of this service providing training to staff and advice as needed.There is a job description for the IC nurse, including the role and responsibilities of the infection control coordinator.  |
| 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 clinical nurse manager provides an IC report to the three monthly infection control meeting, the quality meetings and staff and registered staff meetings. The IC nurse can access external DHB, IC nurse specialist and GPs specialist advice when required. There are strong links developed with public health service.The IC nurse has attended IC training provided by the DHB.  |
| 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 | Springlands has infection control policies and an infection control manual through an external provider, which reflect current practise and have been regularly reviewed. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | All new staff receive infection control education at orientation, including hand washing and preventative measures and regular ongoing training through compulsory training days, which are well attended. The service records education session content, attendance records and competency. Resident education occurs as part of care delivery. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until better. |
| 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 monitoring is the responsibility of the IC nurse officer (the clinical nurse manager). The surveillance activities are appropriate to the acuity, risk and needs of the residents. All infections are entered into the electronic database, which generates a monthly analysis of the data and includes benchmarking against other similar services. There is evidence that results of surveillance outcomes are acted upon.Infection data analysis outcomes are discussed at appropriate levels at infection control, registered staff, and management and quality meetings. Monthly management reports to the GM and directors also include infection data analysis.There is evidence of GP involvement and laboratory reporting.An outbreak in August 2016 was contained to the hospital wing. Public Health, the Medical Liaison ICC Team Canterbury and the Southern Community Laboratories were notified and the DHB IC liaison person was used as a support during the outbreak. The outbreak was contained to seven residents and three staff with a total lock down period of 10 days.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service has comprehensive policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The service currently has no residents requiring the use of restraint and one hospital resident with an enabler. The resident had consented to the use of the enabler and the care plan was up to date and included reference to the enabler in use.Restraint meetings and audits are undertaken twice a year and are documented. The service, led by the restraint coordinator, has implemented practices and procedures that have eliminated restraint use.  |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | CI | Springlands Village reviews the use of restraint as part of its internal audit processes. The results of the restraint audit are discussed at the monthly meetings and three times a year restraint meetings. Any corrective actions identified are actioned through these meetings. The service is proactive with reviewing restraint use and working towards reducing the use of restraint. Benchmarking occurs with other similar services around restraint use. The service identified a goal to reduce restraint use and has exceeded the required standard in achieving this through detailed quality review and analysis of restraint use. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.4.3The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | The service intends that all pressure injuries are reported through the electronic incident reporting system. The registered nurses and clinical nurse manager interviewed were aware of this requirement. During review of files it was identified that one of the two current pressure injuries had not been reported as an incident (this was rectified during the audit). The sample was then extended to all 14 pressure injuries in 2016 (mostly grade one with some grade 2) and the issue was confirmed. | Two of the fourteen pressure injuries in 2016 had not been reported as incidents. | Ensure all pressure injuries are reported as incidents.90 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Wound assessment, treatment and evaluation plans are in place for all wounds, however not all wound care documentation was fully completed or updated. All incident forms documented follow-up by a registered nurse but assessment by a registered nurse was not evidenced to be consistently completed when there was a documented change in resident health status. | i) One hospital and one rest home resident had multiple wounds recorded on one wound assessment, treatment and evaluation form.ii) The dressing application form (assessment) was not fully completed for six of eleven wounds reviewed. Entries did not document size of wound to monitor progress towards wound healing.iii) Concerns documented in two rest home residents progress notes; one resident with an episode of chest pain and one resident with bruising noted on admission, did not evidence a follow-up assessment completed by a registered nurse. | i-ii) Ensure that all wound documentation is fully completed for every individual wound.iii) Ensure registered nurse follow-up of resident or staff concerns.90 days |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.9Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;(b) A process that addresses/treats the risks associated with service provision is developed and implemented. | CI | There is a designated health and safety officer. Staff interviewed were knowledgeable about health and safety. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. The hazard register is up-to-date and reviewed at three monthly health and safety meetings. The service has reviewed and improved the health and safety management programme to a level that exceeds the required standard and as a consequence outcomes for residents have improved. | Following the restructuring of the health and safety programme and ACC secondary level accreditation, the health and safety team determined that interventions and a plan implemented by them could improve manual handling and improve outcomes for staff and residents, specifically to reduce skin tears resulting from staff handling in a three month period. Manual handling education has been provided to staff three monthly, as has health and safety education. Staff were educated around the importance of moisturising residents skin to prevent injury and this was monitored and limb protector use was introduced for high risk residents as a result of the skin tear rate of 8.36 skin tears per thousand bed days to 3.91 in August 2016, 2.86 in September 2016 and 1.68 in October 2016. |
| Criterion 1.3.13.1Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | Food and nutritional needs are met and special diets including those for diabetic and purred are catered for. The service takes significant interest in catering to the likes and dislikes of residents. | Following the resident food survey in 2015, the service identified that residents would prefer more food choices.At the time of the results from the survey, they were offering a 2-choice menu, however not all residents were aware of this. The service advised residents of this information via the village newsletter following the survey.The menu was sent to the nutritionist for review who then visited the site to observe lunch service and provide feedback on menu. The food service and menu review report was received and implemented. As a result of this the number of residents identifying that there was sufficient choice in the menu increased from 60% in April 2015 to 82% in July 2016. |
| Criterion 2.2.5.1Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:(a) The extent of restraint use and any trends;(b) The organisation's progress in reducing restraint;(c) Adverse outcomes;(d) Service provider compliance with policies and procedures;(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;(g) Whether changes to policy, procedures, or guidelines are required; and(h) Whether there are additional education or training needs or changes required to existing education. | CI | Restraint processes are reviewed through benchmarking, internal audits and ongoing review of restraints by the restraint coordinator and at facility meetings, including the restraint meeting. This process has been implemented in a manner that exceeds the required standard. | The team (led by the restraint coordinator) at Springlands Lifestyle Village identified a goal in January 2015 to actively minimise and reduce restraint and enabler use. Intensive education, including increasing staff awareness of the hazards of restraint and providing knowledge about assessing and managing resident behaviours that were likely to lead to the use of restraint, was provided. Alternative strategies using the environment (for example positioning of beds or fall out mattresses) and care related options were explored and identified and diversional therapy involvement was increased for identified at risk residents. As a result of these interventions, restraint and enabler use has consistently dropped from seven restraints and two enablers in January 2015 to nil restraints and one enabler at the time of the audit. |

End of the report.