

# Lonsdale 2005 Limited - Lonsdale Total Care Centre, Riverside Lodge

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## 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](#).

The specifics of this audit included:

<b>Legal entity:</b>	Lonsdale 2005 Limited
<b>Premises audited:</b>	Lonsdale Total Care Centre  Riverside Lodge
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 27 February 2017      End date: 28 February 2017
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	53



# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Lonsdale Total Care and Riverside Rest Home provides care for up to 70 residents across two sites. Lonsdale Total Care provides hospital (medical and geriatric) and dementia level care and Riverside Rest home provides rest home level care. On the day of the audit there were 53 residents across the two sites. The service is managed by a general manager (registered nurse) and a household manager. The residents and relatives interviewed spoke positively about the standard of care and support provided at both facilities.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

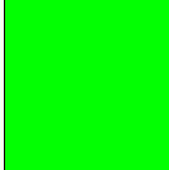
The general manager is well qualified and experienced and is supported by a registered nursing team. There are quality systems and processes embedded and being implemented. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care. Staffing has been stable.

There has been a refurbishment and re-build of part of the hospital including care rooms with ensuites, family lounge and nurses' station. There is a new kitchen as part of the redevelopment programme.

This certification audit identified an area for improvement around interventions.

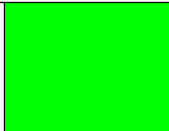
The service has been awarded a continuous improvement rating around quality data, volunteer involvement in the activity programme and infection surveillance.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Lonsdale Total Care Centre and Riverside Lodge practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided. Individual values and beliefs are considered on admission and continuing through the care planning process. There is an open disclosure policy that staff understand. Family/friends are able to visit at any time and ongoing involvement with community activity is supported. Complaints processes are being implemented and complaints and concerns are managed and documented.

## 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.
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The service has an annual business and quality plan in place with annual quality objectives. Quality information is reported to monthly staff/quality meetings, weekly management meetings and to the CEO. The service is actively involved in ongoing quality projects to improve outcomes and service delivery for the residents. Staff interviewed confirmed they are kept informed on risk

management matters, outcomes of internal audits and receive meeting minutes. The service has comprehensive policies/procedures to provide rest home, hospital and dementia level of care. There is an orientation programme in place. There are documented job descriptions for all positions, which detail each position's responsibilities, accountabilities and authorities. There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff and registered nurses on duty to safely deliver care within a timely manner. There is an annual education planner in place that includes compulsory training for aged care staff.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The service has assessment processes and resident's needs are assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, resident care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools including interRAI assessments and monitoring forms were available and implemented. Care plans were individualised and identified involvement of allied health professionals.

A diversional therapist coordinates and implements an integrated activity programme across the two sites. She is supported by a trainee diversional therapist and many volunteers. The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting entertainers.

There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three-monthly.

All meals and baking is prepared and cooked on-site at each facility. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training. Additional snacks were available 24 hours.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The buildings hold a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. Some rooms have an ensuite. There is access to an adequate number of communal toilet/shower facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems and supplies are in place for essential, emergency and security services. There is at least one staff member on duty with a current first aid certificate.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. There were eight hospital residents with restraint on the day of audit.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinators are responsible for coordinating and providing education and training for all staff. The infection control coordinators have attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control team uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections.



## 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)
<b>Standards</b>	1	48	0	1	0	0	0
<b>Criteria</b>	3	97	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Lonsdale Total Care Centre and Riverside Lodge practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and posters of the Code are displayed in both facilities. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with eight care staff (three healthcare assistants (HCA) from Lonsdale and one HCA from Riverside, three registered nurses (two RNs from Lonsdale and one RN from Riverside) and one diversional therapist) reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission and sighted in eight of eight resident files reviewed (three hospital including one respite resident, four rest home residents including one younger person at Lonsdale and one rest home resident at Riverside and two dementia care residents at Lonsdale). Advance directives for continuing care (where appropriate) were completed and on the resident files. Resuscitation plans were sighted in all files and were signed appropriately. Copies of enduring power of attorney (EPOA) were present in resident files. The EPOA of two of two dementia care resident files reviewed had been activated.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents and where</p>

consent.		<p>appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The HCAs and registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>All seven long-term resident's files sampled had signed admission agreements on file.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Advocacy pamphlets are displayed in the entrance to the hospital wing and dementia unit and at both the Lonsdale and Riverside Lodge front entrance. Healthcare assistants interviewed were aware of the resident's right to advocacy services and how to access the information. Resident advocates are identified on admission. Interviews with residents and relatives confirmed that they are aware of their right to access advocacy.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service maintains key linkages with other community organisations including senior citizens, RSA, churches and schools. Residents are invited to community functions and events. A volunteer programme brings the community into the facility (walking groups, swimming groups etc.). Visiting arrangements are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Families interviewed state they are always made to feel most welcome when they visit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy stated that the general manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. There is a complaint's register that includes relevant information regarding the complaint, acknowledgment within the required timeframe, investigation, outcomes, follow-up letters, offers of advocacy and resolution. There were ten complaints (three verbal and seven written) for 2016. A relative complaint through the DHB (2017) is currently being investigated and remains unresolved. Appropriate services have been involved and corrective actions taken by the service. Complaints information is in the information pack at entry. There are complaints forms and advocacy brochures available. Management operate an open-door policy.</p>
Standard 1.1.2: Consumer	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents</p>

<p>Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>and their family. This information is available at reception. The general manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the bi-monthly resident/family meetings. Nine residents interviewed (four rest home at Riverside, three rest home and two hospital at Lonsdale) and six relatives (three rest home, two hospital and one dementia care) at Lonsdale reported that the residents' rights are being upheld by the service. Residents and family members interviewed state they received sufficient verbal and written information to be able to make informed choices on matters that affect them.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff have received training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Māori consultation is available through the documented iwi links and relationship with the Te Wairoa Medical Centre. There is a spiritual advisor and relationship facilitator for Māori residents. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All HCAs interviewed were aware of the importance of whānau in the delivery of care for Māori residents. One resident who identified as Māori had a cultural assessment completed that identified the resident's iwi, cultural values and beliefs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>

ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with HCAs confirmed their understanding of professional boundaries, including the boundaries of the HCAs' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Healthcare assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with four HCAs could describe how they build a supportive relationship with each resident.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The CEO and management team are committed to providing services of a high standard, based on the service philosophy of care. This was observed during the day with the staff demonstrating a very caring attitude to the residents. Residents interviewed state they are very happy with the level of care provided. The service has implemented policies and procedures that are developed and reviewed by key people within the organisation. The policies and procedures meet legislative requirements. The service identified an opportunity to improve practice around the prevention of pressure injuries (link 1.2.3.6). Healthcare assistants interviewed state there are healthcare assistant guidelines in place to guide the delivery of care to residents. They receive a verbal handover from the RN and there is a daily handover sheet for every shift that details any significant events. A communication book is used to ensure staff are kept informed on daily matters.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families and the management team promotes this. The information pack contains a range of information regarding the scope of service provided to the resident and their family on entry and any items they have to pay for that is not covered by the agreement. Residents receive a regular newsletter (The Goss) that keeps them informed on all matters that affect them, community news and facility renovations.</p> <p>The information pack is available in large print and advised that this can be read to residents. Interpreter services are available as required. Relatives interviewed, stated that they are informed when their family member's health status changes. Discussions with HCAs and RNs identified their knowledge around open disclosure. There are resident meetings held bi-monthly at both sites with the opportunity for feedback on the services.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Lonsdale Total Care Centre is a 50-bed facility that provides rest home, hospital/medical and dementia level care. Occupancy on the day of audit was 35 residents. There were ten rest home residents including two YPD residents, seventeen hospital residents including two YPD residents and one resident on respite care. There were eight residents in the dementia unit. There are 10 dual purpose beds. All other residents were under the Aged Related Residential Care (ARRC) contract.</p> <p>Riverside Lodge is a 20-bed rest home. The total number of residents at Riverside Lodge on the days of audit was eighteen residents including one resident on respite care.</p> <p>A general manager (RN) manages the two facilities and has been in the role since October 2014 and with the service for over five years. The general manager also oversees clinical management. The general manager is supported by a household manager and office manager. The household manager oversees the non-clinical services and has been in the position for 10 years. The general manager has maintained at least eight hours of professional development annually, attending relevant courses and forums provided at the DHB.</p> <p>The CEO (owner) meets monthly with the general manager, the general manager of the education centre, household manager and office manager.</p> <p>The 2017-2018 annual business/quality plan has been developed. The business/quality plan clearly identifies the purpose, scope, values and direction of the organisation. Key clinical goals are indicated in the plan around falls prevention, interRAI assessments, care planning, medication management and supporting technology including the implementation of an electronic resident data base and record system. Management meeting minutes sighted evidenced regular reviews of the 2016-2017 annual business/quality plan.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>The general manager of the education centre (former facility manager/RN) is the acting manager during the temporary absence of the general manager.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There are policies to guide the facility to implement the quality management programme including (but not limited to): quality assurance and risk management programme, management responsibilities, health and safety and infection control responsibilities and internal audit schedule. Quality information is discussed at the monthly staff meetings and weekly management meetings. Staff interviewed stated they are well informed and receive quality and risk management information such as accident/incident stats and infection control stats. Reports are provided from the health and safety representatives and infection control coordinators to the management meeting. The HCAs interviewed speak highly of the management team and state they are asked for suggestions and feedback on quality initiatives.</p> <p>An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed. The quality and risk management programme also includes health and safety and hazard identification. Staff report any hazards identified on the daily maintenance request/hazard form. Falls prevention strategies are in place that includes the analysis of falls incidents and accidents and any areas for improvement. The service has reduced the number of falls and increased the number of residents on the vitamin D programme. Prevention strategies and corrective actions are documented in the resident's care plan.</p> <p>Satisfaction surveys completed annually are residents/relatives (July 2016) and food survey (August 2016). The survey results are collated to identify if there are any areas for improvement. The resident/relative satisfaction survey identified an improvement around laundry; corrective actions were put in place and the results were posted in the monthly residents/relatives (The Goss) newsletter.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accident/incident policy, which is part of the risk management plan. Monthly data collection of accident/incidents is completed. When an incident occurs, the staff member discovering the incident completes the accident/incident form. The incident/accident is documented in the progress notes. The RN on duty completes a clinical assessment and identifies preventative and corrective actions. All incidents/accidents are signed off by the general manager, who conducts a further investigation if required. Sixteen incident forms sampled evidence detailed investigations and corrective action plans following incidents, including neurological observations for three of the resident related incidents.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files were reviewed (one household manager, one lead nurse/RN, two RNs, three HCAs, one cleaner and one cook). The recruitment and staff selection process requires that police vetting</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>and reference checks are completed prior to employment to validate the individual's qualifications, experience and suitability for the role. All files evidence a signed employment contract and job description. Staff files reviewed had annual performance appraisals completed where due. There is an orientation programme in place and staff are orientated to their area of work and complete competencies relevant to their role.</p> <p>There is a documented annual education/training programme. There are monthly mandatory core training days that cover compulsory requirements. Competencies are identified and completed. Registered nurses and HCAs are encouraged and supported to undertake external education. At least eight hours of staff development or in-service education has been provided annually. Eight HCAs are employed in the dementia unit. Six HCAs have completed the required dementia standards. Two HCAs have been employed less than 12 months and are enrolled to commence the dementia standards.</p> <p>All volunteers receive an orientation including induction to Code of Rights and health and safety.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs on different shifts.</p> <p>There is one RN rostered across the dementia unit and Lonsdale resthome (across seven days). There is one RN in the hospital in the morning, one RN in the hospital in the afternoon and one RN in the hospital overnight.</p> <p>Riverside also has one HCA on duty for the morning, afternoon and night shifts.</p> <p>The lead nurse/RN at Lonsdale is the on-call RN and is supported by a rostered on-call RN that can be called at short notice to assess a resident or cover for a RN who is unexpectedly absent. Staff at Riverside access the RN at Lonsdale after hours for advice and the on-call RN if a clinical assessment is required. The general manager (RN) covers both facilities and works full-time. Residents and relatives interviewed confirm that there are sufficient staff on-site at all times and staff are approachable and in their opinion, competent, respectful and friendly.</p> <p>In the dementia unit; there is two caregivers in the morning, two in the afternoon and one at night.</p> <p>On night shift – there is one caregiver in the dementia unit, one caregiver and one RN in the hospital/RH and one caregiver at Riverside.</p> <p>Caregivers interviewed stated that there was sufficient staff and any absentees get replaced within the team.</p>
<p>Standard 1.2.9: Consumer</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial</p>



<p>Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure office in all areas. Care plans and notes are legible, signed and dated by the RN or HCA. All progress notes are entered on the electronic resident database.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs including information on the dementia care service is provided for families and residents prior to or on admission. Prior to entry, all potential residents have a needs assessment, completed by the needs assessment and coordination service to assess suitability for entry to the service.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses and HCAs who administer medications have been assessed for competency on an annual basis. Registered nurses complete syringe driver training. Education around safe medication administration has been provided. Medications are checked on delivery by the RNs at each site. There were no standing orders at time of audit. There were no residents self-medicating on the day of audit. All medications are stored safely at Lonsdale and Riverside. All eye drops at both sites were dated on opening. The medication fridge is monitored daily at Lonsdale at least weekly at Riverside.</p> <p>All sixteen medication charts reviewed (six hospital, six rest home and four dementia care) on the electronic medication system met legislative prescribing requirements. The GP has reviewed the medication charts three-monthly.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The kitchen at Lonsdale has been fully renovated and extended in April 2016. During the renovations, the meals were prepared on-site in a temporary container. The kitchen supervisor (interviewed) stated the team had input into the renovations. The kitchen is well equipped with new appliances, has a good work flow and good size pantry and food storage areas. The cook on duty is supported by morning and afternoon kitchen hands. There is a four-week summer and winter menu at Lonsdale and Riverside that has been reviewed by a dietitian. At Lonsdale, meals are delivered in a bain marie to the rest home and hospital dining rooms. Meals for the dementia care residents are plated and delivered in a hot box to the dining area. Dietary requirements for residents are known and accommodated such as pureed, soft and dairy-free meals. There are nutritious snacks available 24 hours in the dementia unit kitchenette.</p> <p>There is a cook and kitchen hand on duty at the Riverside kitchen. The cook receives resident dietary profiles and dislikes and dietary requirements are accommodated including soft diets.</p> <p>All food services staff have completed food safety units and refreshers. End cooked temperatures are taken and recorded daily. Fridge, freezer and dishwasher temperatures are monitored daily. All goods in the pantry were date labelled. All perishable foods in fridges were date labelled. Chemicals are stored safely. Staff were observed wearing personal protective clothing. Cleaning schedules are maintained.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>The admission policy describes the declined entry to services process. Lonsdale and Riverside record the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whānau back to the referral agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RN completes an initial assessment on admission including risk assessment tools. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summary were in place for all long-term resident files sampled. The long-term care plans in place reflected the outcome of the assessments.</p>
<p>Standard 1.3.5: Planning</p>	PA Low	<p>Resident care plans reviewed were resident focused and individualised. Overall identified support needs</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>were included in the care plans for all long-term resident files reviewed. A short-term care plan was in place for the respite care resident. The two files of residents in the dementia care unit contained a comprehensive behaviour management plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration and evidence of allied health care professionals involved in the care of the resident such as the physiotherapist, hospice service, pain management team and mental health services.</p> <p>Short-term care plans were in place for short term needs. Short-term care plans had been reviewed regularly and either resolved or transferred to the long-term care plan if an ongoing problem.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to): accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds and skin tears. There were no pressure injuries on the day of audit. There was a range of equipment readily available to minimise pressure injury.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p> <p>Short-term care plans document appropriate interventions to manage short term changes in health. Not all interventions had been documented to meet the resident's needs/supports (link 1.3.5.2).</p> <p>Monitoring occurs for weight, vital signs, blood glucose, pain, challenging behaviour, wounds, restraint and continence. Registered nurses review the monitoring charts and report identified concerns to the GP, nurse practitioner or nurse specialist.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>CI</p>	<p>The service has a qualified diversional therapist (DT) who oversees a trainee who is completing the DT qualification. The activity team provide an integrated rest home, hospital and dementia activity plan Monday to Friday. The DT spends one day a week at Riverside Rest Home and ensures residents are invited and transported to activities and entertainment at Lonsdale. There are organised activities during the week and</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>other activities initiated by the HCAs in the weekends. Activities are held in several locations within the facility. The variety of activities meets the abilities of all residents. There are many volunteers involved in the activity programme. Volunteers also spend one-on-one time with the younger persons. Entertainers attend the home regularly and there are regular outings and drives for all residents at both facilities. Residents are supported to attend religious services. Residents are encouraged to maintain links within the community including schools. The service provides transport for residents to attend their community groups. There are a variety of activities catering for individual resident needs including special garden projects and adapted games (circle bowls). Special events and festivities are celebrated and families are invited to attend.</p> <p>One-on-one time or small group activities are carried out with the dementia residents (observed on the day of audit). Healthcare assistants in the dementia unit facilitate small group or individual activities at other times. There are adequate resources available.</p> <p>An activity assessment and plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed six-monthly.</p> <p>Residents and families have the opportunity to feedback on the activity programme through meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans reviewed were evaluated by the RN within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. The written evaluation documents the resident's progress against identified goals. The GP reviews the residents at least three-monthly or earlier if required. The multidisciplinary team includes the general manager (clinical), DT, registered nurse, resident/relative and any allied health professional involved in the care of the resident. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Changes are made to care plans.</p>
<p>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</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>

<p>facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. The chemical provider monitors the use of chemicals and provides chemical safety for all relevant staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Lonsdale Total Care building has a current building warrant of fitness that expires 31 March 2017. The Riverside Rest Home building has a current building warrant of fitness that expires 12 December 2017.</p> <p>Lonsdale is a large, spacious single story building with safe internal access between the bedrooms and communal areas of the rest home and hospital. There has been a complete re-development of the hospital end of the building with a new kitchen, nurses' station, family lounge, sluice room, new resident rooms, staff room and visitor's toilet.</p> <p>Riverside is a single-story home set in a beachside community with a home-like environment. Hallways in both facilities are sufficiently wide enough to allow residents to mobilise with the aid of walking frames safely and other mobility aids.</p> <p>There is a full-time maintenance person that is employed for both facilities. There is a maintenance log book for repairs and maintenance requests. Minor repairs are addressed and signed off. Essential contractors are available 24 hours. There is a monthly planned maintenance plan that includes environmental and resident equipment maintenance. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated annually. Planned maintenance includes call bell and hot water temperature monitoring monthly.</p> <p>The facilities have wide corridors with handrails and sufficient space for residents to safely mobilise using mobility aids.</p> <p>There is safe access to outdoor areas. Seating and shade is provided.</p> <p>The dementia care unit has exit and entry points to the safe outdoor walking pathway and garden areas</p>

		<p>which provide seating and shade.</p> <p>The RNs and HCAs (interviewed) at both sites stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Lonsdale Total Care - toilet and shower facilities are of an appropriate design to meet the needs of the residents. Four resident rooms in the re-developed area of the hospital unit have shared ensuites and two resident rooms have their own ensuite. There are sufficient numbers of communal toilet/showers in each unit. The hospital unit has a large shower room that can accommodate a shower trolley. Privacy curtains and engaged/vacant signs ensure resident privacy.</p> <p>Riverside Rest Home – there are adequate numbers of communal toilets and showers. Privacy curtains and engaged/vacant signs ensure resident privacy.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>At Lonsdale, five of the dual-purpose rooms are double rooms. In the hospital unit, there are three bedrooms (triple beds) and two double rooms. There are two double rooms in the dementia unit. All other rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms.</p> <p>All resident rooms at Riverside Rest Home are single.</p> <p>Residents and families are encouraged to personalise their rooms. This was evident at both sites on audit day.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their</p>	FA	<p>Lonsdale Total Care - The main rest home has an open plan lounge and dining area kitchen. The hospital has a large open plan lounge and dining room. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. There are seating areas within the facility and a family lounge with tea making facilities. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this.</p> <p>In the dementia care unit at Lonsdale, there is adequate space to allow maximum freedom of movement while promoting safety for those that wander. The dementia unit has a quiet lounge and a separate dining</p>

<p>relaxation, activity, and dining needs.</p>		<p>area. There is a smaller activity lounge and seating alcoves within the unit.</p> <p>Riverside Lodge has a separate spacious dining area, main lounge, seating alcoves and sunny conservatory that allows for group and individual activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. Lonsdale Total Care has an external laundry building with defined clean/dirty flow. There is a dedicated laundry person. All personal clothing and linen is laundered on-site. The new washing machine has an outbreak cycle. All equipment has a six-monthly service.</p> <p>At Riverside Rest Home, personal clothing is laundered on-site in a well-functioning laundry. All linen is laundered off-site.</p> <p>The contracted chemical supplier monitors the effectiveness of the cleaning and laundry processes. The cleaner's trolleys at both sites are well equipped and are kept in designated locked areas when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing.</p> <p>Lonsdale Total Care- civil defence supplies are readily available on-site including a 1,000L water tank, other bottled water store (changed six-monthly), adequate food storage, gas and electric cooking appliances and a barbeque. The service has purchased a diesel generator which is to be connected to the hospital mains.</p> <p>At Riverside Rest Home there are adequate civil defence supplies including water and food storage. There is a battery backup in the event of a power failure.</p> <p>The fire evacuation scheme was approved by the fire service 1992 for both facilities. There are six-monthly fire drills. Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.</p> <p>Resident's rooms, communal bathrooms and living areas all have a wireless call bell system that generates call on staff carrying pagers. Security policies and procedures are documented and implemented by staff. The buildings are secure at night with doorbell access.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. There are sufficient doors and opening windows for ventilation. All</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>bedrooms have good sized windows which allows plenty of natural light.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control team. There is infection control coordinators (RN) at each facility. The infection control programme is linked into the quality management system and reviewed annually by the infection control team (infection control coordinators, general manager and household manager).</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the two facilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinators (RN at each site) attend external education annually. The service is affiliated with an external infection control organisation for any advice or updates for policies.</p> <p>The infection control team meet monthly and provide reports at the clinical review meetings. The facility has access to an infection control nurse specialist at the DHB, external infection control consultant, public health, laboratory, GP's and DHB wound nurse.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are</p>	<p>FA</p>	<p>There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. The infection control policies (last reviewed September 2016) link to other documentation and cross reference where appropriate.</p>



implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinators are responsible for coordinating and providing education and training to staff. The orientation package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs annually as part of the annual training programme. Staff are required to complete infection control questionnaires following education.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinators collate information obtained through surveillance to determine infection control activities and education needs in the facility. Infection reports are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>Infection control data is discussed at the monthly clinical review meetings and presented by power point including graphs of infection events. Monthly and annual comparisons are made for the type and incidence of infection rates. Internal audits for infection control are included in the annual audit schedule.</p> <p>There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There has been one confirmed norovirus outbreak in September 2016 which was well managed and contained to one unit. Relevant authorities were notified and a debrief for staff was held at the clinical review meeting.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	FA	<p>There are policies around restraints and enablers last reviewed January 2017. The service currently has eight residents assessed as requiring the use of restraint (five with bed gates and lap belt and three with bed gates only). There is a restraint coordinator (RN) who reports to the RN meetings and general manager. There is documented evidence of consultation with the resident and family/whānau regarding the use of restraint. Residents voluntarily request and consent to enabler use. There were no enablers in use on the</p>

minimised.		<p>day of audit.</p> <p>Staff receive training around restraint minimisation on orientation and as part of the annual education programme.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>A restraint approval process and a job description for the restraint coordinator/RN are in place. The resident/family/whānau as appropriate are consulted prior to the use of restraint and receive written information on restraint use. The GP is involved in the approval process. Five of eight care plans reviewed for residents on restraint identified the use of restraint. Healthcare assistants interviewed were knowledgeable on the use of restraint and approval processes.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. Five hospital level residents' files where restraint was being used were selected for review. Each file included a restraint assessment completed by a RN or restraint coordinator. The consent forms were signed by the resident's family and GP. Restraint use is linked to the resident's care plan; however, in three of five care plans reviewed there were no risks identified with the use of restraint (link 1.3.6.1).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>A restraint register is in place. The register identifies the residents that are using a restraint and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. The electronic system for resident records including the progress notes, includes a declaration for the monitoring of restraints and cares delivered throughout the restraint use.</p>
<p>Standard 2.2.4: Evaluation</p>	FA	<p>Restraint use is reviewed monthly by the restraint coordinator and reported to the RN meeting. Restraint use is reviewed six-monthly as part of the care plan review. The review process includes discussing whether</p>

Services evaluate all episodes of restraint.		continued use of restraint is indicated.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the restraint coordinator and general manager as part of the internal review. Restraint audits identify opportunities for improvement.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	Resident care plans reviewed were resident focused and individualised. Overall identified support needs were included in the care plans for all long-term resident files reviewed. However not all interventions were documented to manage pain and restraint risks.	(i) There were no documented interventions for the management of pain for one rest home resident at Lonsdale, and (ii) there were documented risks around the use of restraint for three of five hospital residents on restraint.	<p>(i) Ensure there are documented interventions for pain management and (ii) ensure restraint risks are documented for all residents on restraint.</p> <p>90 days</p>

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	<p>The service implemented a project around improving the practice to eliminate pressure injuries by early recognition of residents with pressure injury risk and early intervention.</p> <p>The service identified there were increased numbers of mobile residents at risk of falls and falls with injury who were not on the Vitamin D programme, as recommended by the district health board (DHB). The service initiated a falls prevention programme to reduce the number of falls across the three levels of care. The aim of the falls prevention programme is to reduce the overall number of falls and to reduce the harm caused. The service has focused on the</p>	<p>An action plan was developed with a target to eliminate pressure injuries (PI). Over 2015 and to August 2016 there were a number of pressure injuries including two grade II (heel and sacrum) and one grade III (from hospital). There was a focus on education with funding set aside for specific education on pressure injury prevention for RNs and HCAs. Education for RNs also included risk assessments and integrating outcomes into care plans and monthly team talks. A review of PIs, resources and healing progress including photos were part of the discussion at clinical review meetings. A review of pressure injury risk assessments in October 2015 identified a gap around six-monthly reviews and identifying residents at risk. This has been corrected and all residents have risk assessments completed and reviewed at six months or earlier. The daily electronic progress notes require the HCAs to report on daily skin checks of residents in their care. From October to December 2016 the service had eliminated pressure injuries. A grade I PI noted on a sacrum in January 2017 was promptly noted by care staff, managed and resolved. The service has been successful in changing the culture to increase awareness around pressure injuries, risk</p>

		<p>factors that are within their control, the '5 essentials of falls prevention'. The service has encouraged the local GP's to prescribe Vitamin D unless contraindicated and have made a feature of being highly "falls aware" in every possible forum (e.g. minutes of regular staff Teamtalks around falls data and progress on falls prevention).</p>	<p>assessments, early detection and intervention to actively eliminate pressure injuries.</p> <p>The service continues to implement a falls prevention programme since previous audit. Data since March 2015 shows a reduction in the total number of falls from an average of 13 per month to an average of 6 per month. The usage of Vitamin D at Lonsdale and Riverside facilities has increased to exceed the DHB target of all residents on Vitamin D. Discussions were held with the GPs who assessed each resident's risk and prescribed Vitamin D accordingly. All Vitamin D usage is reviewed three-monthly by the GP. The overall service has improved as staff are more falls prevention aware, report any "unplanned change of level" as a fall and make requests for safety equipment as requested. Fewer falls overall on average over a two-year period, with no fractures as a result of falls in that time.</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>There are 14 volunteers involved in the various activities offered in activity programme. Volunteers are supported and reflective of the community support.</p>	<p>The volunteer group includes retired staff members, family members, pastoral visitors, regular entertainers and pet therapy owners. All volunteers receive an orientation including induction to Code of Rights and health and safety. Volunteers work alongside the DT and are involved in assisting residents with board games, outings, walks and church services. Two family volunteers spend time with residents in the dementia care unit. Some volunteers spend one-on-one time with the younger persons' and others help with drives and outings. Volunteers have made the difference for residents in that many activities would not be possible without volunteer support. There has been increased attendance at activities as the volunteers are available to assist residents with activities such as bingo, crafts, walks and outings. The level of volunteer involvement and activity is reviewed monthly and has been maintained as documented in the DT monthly reports. The resident/relative survey has a response of very satisfied with the activities programme and volunteer involvement. The service acknowledges volunteers at Christmas when they all come together and receive gifts of thanks from the team and residents.</p>

<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>Trends are reviewed monthly and goals identified with preventative measures put in place. Infection control goals are reviewed and discussed at each infection control team meeting. The service identified an upward trend in urinary tract infections and skin infections July 2016 and has been successful in reducing and maintaining low rates especially over the warmer months</p>	<p>The service developed an action plan to reduce UTIs and skin infections by 50% by January 2017. The number of UTIs and skin infections had increased in July 2016 and the service identified a pattern over previous years of increasing numbers of infections in the warmer months over summer. The action plan included: increased discussion and presentations at clinical review meetings, internal audits, team talks, roster emails, education and awareness through hand hygiene, perineal care (HCAs), wound care (RNs), catheter cares and fluid/hydration promotion. The service also identified “blue hands in the corridor” and launched a campaign to reduce inappropriate use of gloves. An evaluation of the action plan evidenced an improvement in infection control practice and use of gloves, hydration rounds offering fluids in a variety of forms e.g. ice blocks. The service has been successful in reducing UTIs from five in July 2016 to one in November and December and none in January 2017. Skin infections reduced from nine in July 2016 to zero in November and one in December 2016 and January 2017. The service has achieved greater than 50% reduction in UTIs and skin infections.</p>
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End of the report.