Lady Joy Home Limited - Lady Joy Rest Home

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Lady Joy Home Limited
Premises audited:	Lady Joy Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 31 May 2017 End date: 31 May 2017

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: 17

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Lady Joy Home provides rest home level care for 31 residents. The service is a privately-owned family business. One of the owners, who is a registered nurse, is the nurse manager, with the other owner being the managing director. Residents and families spoke positively about the care and services provided.

This surveillance audit was conducted against the relevant Health and Disability Services Standards and the services contract with the district health board. The audit process included sampling of policies and procedures, residents` and staff records. Observations and interviews were conducted with residents, families, management, staff and a general practitioner.

There were no areas of improvement that were required to be followed up from the previous certification audit. This audit identified that there were no systemic issues and all the relevant standards are met.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Communication is conducted in an open and honest manner that reflects the organisations open disclose policy.

There is a documented complaints process in place that complies with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). There are no outstanding complaints.

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.

A business plan and quality and risk management plan is documented and includes the mission and goals of the service. There is a process in place for the regular reporting against these goals.

The facility is managed by an experienced and suitably qualified manager, who is a registered nurse.

Quality management data is collected and discussed at staff meetings and staff could describe this. There is an implemented internal audit programme. Corrective action plans are in place where necessary. Adverse events are documented and there is evidence of good follow-up of these. Open disclosure is documented as it occurs.

There are policies on human resources management. Practising certificates are current for all registered nurses, one enrolled nurse and associated health professionals. Staff records have the required information, including staff education records. Staff report good access to training. An orientation programme is in place and completed.

There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. The facility manager and senior staff are rostered on call after hours. Care staff reported there are adequate staff available.

Continuum of service delivery

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

The clinical manager is responsible for care plan development with input obtained from residents, staff and family members. Assessments and care plans are developed and evaluations completed within the required time frame. Planned activities are appropriate to the resident's assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

Medicines are managed and administered in line with the sighted medicines management policy. Medicines are monitored and reviewed every three months or as required by the GP. The service uses a pre-packaged medicine system in prescribing, dispensing and administration of medicines. Staff involved in medicine administration are assessed as competent. Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

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.

There is a current building warrant of fitness in place. There have been no changes to the current layout of the service since the last audit.

Restraint minimisation and safe practice

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

There are clear and comprehensive documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated understanding of restraint and enabler use and receive ongoing restraint education.

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 type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. General practitioner (GP), or other specialised input, is sought as required. Staff and residents reported that they are informed of any infection issues within the facility.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	39	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints and concerns policy which meets the requirements of the Code of Rights. There is a flowchart associated with the policy to assist staff in understanding the process for complaints management. Residents and their families receive a copy of the policy in the welcome pack and there are copies throughout the facility. All concerns and complaints are recorded and managed in the same way. A register is maintained by the nurse manager. The register contains all dates and actions taken, with all complaints recorded to a satisfactory outcome for the complainant. There are no outstanding internal or external complaints. Training on complaints management and open disclosure is provided to staff as part of the ongoing in-service education programme.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to	FA	The cultural policy notes interpreters will be accessed if required. Prior to admission of residents who do not speak English, a senior staff member will offer the availability of the interpreting services to the resident and/or their family. This service can be contacted through the DHB. All current residents speak English. Evidence was seen that all aspects of care and service provision are discussed with the resident and their family/whanau prior to/or at the admission meeting. The residents and family/whanau reported that

effective communication.		communication is open and honest. Open disclosure is documented and is noted on incident forms.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Lady Joy Home is a family owned and operated business. One owner/director is the managing director and the other owner/director is the nurse manager. The service provides rest home level of care for up to 31 residents. At the time of audit there were 17 residents receiving rest home level of care, in addition to this there were two private tenants residing at the home under a supported living/accommodation arrangement. The services are planned to meet the needs of all residents and the people in the supported living rooms. The organisational goals and mission statement are documented in the governance policies. There are at least monthly management meetings, both formal and informal, that monitor the progress to achieving their goals. There is an additional annual management review that evaluates the year's performance and evaluates the structure, suitability and efficiency of the implementation of the quality system, The nurse manager is a registered nurse with a current annual practising certificate. The nurse manager is the management representative with the executive responsibility and authority for all matters pertaining to the clinical services and quality programme. The nurse manager has attended over eight hours' education and training related to the management of the aged care facility, along with additional professional development for their nursing role. The residents and families report satisfaction with the care and services provided at Lady Joy Home.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is a quality and risk management system which includes the quality policy and quality improvement and risk management plan. It is detailed and specifies the roles and responsibilities of all staff members. Management reporting is detailed in the quality improvement and risk plan. The nurse manager is responsible for providing leadership in the facility and for the implementation of the plan, providing educational support for staff and registered nurses. The quality and risk system reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular satisfaction survey, monitoring of outcomes and clinical incidents including infections. Meeting minutes sampled confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities. The data gathered from the quality and risk system is monitored and evaluated monthly. If any are scores are below the identified goal threshold, a quality improvement plan is implemented. The quality improvement plans sampled identify the corrective action, who is responsible, timeframes for implementation and verification of the actions taken.

		Feedback is provided to staff and where appropriate the residents and family/whanau. Resident and family satisfaction surveys are completed annually. The most recent survey showed positive feedback. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility tool and process. All policies and documents sampled are updated and are relevant to the scope and complexity of the service and reflect current accepted good practice. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The governance and risk policies described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The managing director is familiar with the recent health and safety legislative changes and has implemented changes.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Adverse events are documented on an incident/accident form and these are followed up by the nurse manager/RN. The forms and the incident summary reports in the residents file sampled are well annotated with follow-up actions. All serious incidents/accidents are reported to the registered nurse or the nurse manager on duty/on call. Staff confirmed that they are made aware of their responsibilities in this regard during their orientation and in policy and procedures. The management team are aware of the essential notification requirements and these are documented in policy, this include the reporting of stage 3 and above pressure injuries. There have been no notifications of significant events made since the last audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are policies and procedures on human resources management. Annual practising certificates were verified for the staff and associated health professionals who require them. The skills and knowledge required for each position within the service is documented in job descriptions which were evident on each personal record sighted. The staff files sampled confirmed that staff have been police vetted. An orientation process is available and covers all essential components of the services provided. One newly appointed staff member interviewed found the information provided to be informative and supportive. Staff performance appraisals are performed at the end of orientation and annually The 2017 education programme was sampled and evidenced that education is provided, in house, on line and by staff visiting external facilities. The individual records of education are maintained for each staff member and were reviewed. The nurse manager/ registered nurses are trained in the interRAI assessment. Staff interviewed reported that they have access to education and enjoyed the programme. The care staff

		are encouraged to complete national qualifications in the support of the older person, if they do not already have the qualification.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented allocation of staff to complete the duty rosters. The rosters sampled reflect contractual requirements and the needs of the residents. The staff requirements and the resident acuity are reviewed and evaluated as part of the quality system. There is sufficient staff to meet the needs of the residents and the people in the supported living arrangement. In addition to the onsite staff, there is an RN on call after hours. Care staff interviewed reported that there were adequate staff available and that they could complete the work allocated to them. Residents and families interviewed reported that there was enough staff to provide them or their relative with adequate care. Observations during the audit confirmed adequate staff cover is provided, with planned and sick leave replaced.
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	All medicine files sampled confirmed that they are reviewed every three months or as required and discontinued medicines are signed and dated by the GP. Allergies are documented, identification photos are present and three monthly reviews are completed by the GP. Medicine charts are legibly written. Medicines and medicine charts are stored safely and securely and medicine reconciliation is conducted by the RN when the resident is transferred back to the service. The service uses pharmacy pre-packed packs that are checked by the RN on delivery. The controlled drug register is current and correct. Weekly and six monthly stock takes are conducted and all medicines are stored appropriately. There were no residents self-administering medicines at the time of the audit. There is a policy and procedure for self-administration of medicines if required. An annual medicines competency is completed for all staff administering medicines and medicine training records were sighted. The medicines management system complies with current legislation, protocols and guidelines.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service	FA	Meals are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The nutritional needs are provided in line with recognised nutritional guidelines appropriate to the residents at the service. The resident's dietary profile forms are developed on admission which identifies dietary requirements, likes and dislikes and reviewed as needed. Supplements are provided to residents with identified weight loss issues. The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates were on all

delivery.		containers and records of temperature monitoring of food, fridges, freezers and chiller are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. All decanted food had use by dates recorded on the containers and were current. The residents and family/whanau interviewed indicated satisfaction with the food service.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The documented interventions in short term care plans and long term support care plans are sufficient to address the residents assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed and the staff confirmed they have access to enough supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support they are receiving.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The planned activities are meaningful to the residents' needs and abilities at Lady Joy Rest Home. The activities programme covers physical, social, recreational, spiritual, intellectual, emotional and cultural needs of the residents. The activities are modified as per capability and cognitive abilities of the residents. The activities coordinator develops an activity planner which is posted on the notice boards and residents rooms respectively. Residents' files have a documented activity plan that reflects their preferred activities of choice. Over the course of the audit residents were observed engaging in a variety of activities. The residents and family/whanau reported general satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident's long term care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Family/whanau and staff input is sought in all areas of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and	FA	There is a current building warranty of fitness is displayed. There have been no changes to the layout of the building that has required the approved evacuation scheme to be amended.

facilities that are fit for their purpose.		
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities. The nurse manager (infection control coordinator) and a senior caregiver monitor and review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff through the monthly staff meetings and at staff handovers. There is an additional six monthly infection control report that analyses, identifies trends and compares the outcomes of the infection surveillance and preventative actions that have been implemented. When increases in the number of infections or trends are identified, actions are implemented to reduce their reoccurrences. There have been no reported outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint minimisation policy provides consistent definitions for restraints and enablers. No residents were restrained or using enablers on the day of the audit at Lady Joy Rest Home. All staff receive education regarding restraint minimisation and challenging behaviours. Staff interviewed are aware of the difference between a restraint and an enabler.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.