

Holly Lea Village Limited - Holly Lea

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 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:

Legal entity:	Holly Lea Village Limited
Premises audited:	Holly Lea
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 November 2017 End date: 1 November 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:	8

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

Holly Lea can provide rest home or hospital (geriatric) care to up to 21 residents within a 38-apartment complex. On the day of audit, there were eight rest home residents. At the time of the audit no hospital residents had been admitted.

The general manager is a registered nurse and is experienced in aged care and management. The general manager has been in the role since December 2015 and is supported by a clinical nurse manager, registered nurses and care staff.

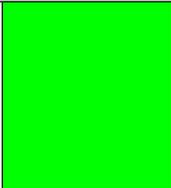
The operational 2016 / 2017 business plan identifies strategic priorities around development opportunities, industry engagement, market leverage 'best in class', value creation, organisational culture and business operations.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, staff and management.

The service has addressed one of the two shortfalls from the previous partial provisional audit relating to the safe storage of chemicals. The shortfall around staff coverage for hospital level residents continues to require improvement, prior to admitting any hospital level resident. The one remaining shortfall identified at the previous certification audit around the inclusion of interRAI in policies has been addressed.

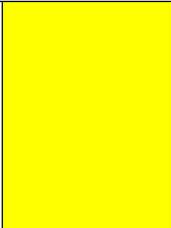
No further areas requiring improvement have been identified at this audit.

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.
--	---	--

Information about services provided is readily available to residents and families/whānau. Residents and family are well informed including of changes in resident's health. The general manager promotes an open-door policy. Complaints processes are 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.		Some standards applicable to this service partially attained and of low risk.
---	--	---

The general manager is a registered nurse and reports to the managing director of Generus Living Group. The quality and risk management programme include service philosophy, goals and a quality planner. Quality activities are conducted, and generate improvements in practice and service delivery. Corrective actions are implemented, followed through and communicated to staff. Health and safety policies, systems and processes are implemented to manage risk. Staff advised that there is an orientation programme that provides new staff with relevant information for safe work practice. Human resource policies are in place, including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of rest home level care and support.

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.
--	--	--

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial care plans, specific assessments and care plans to guide staff in the delivery of care to residents. The care plans are resident, and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three-monthly general practitioner review. The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. Registered nurses and senior healthcare assistants administer medications. Residents' food preferences and dietary requirements are identified at admission and all meals prepared on-site. The kitchen is well equipped for the size of the service. This includes consideration of any particular dietary preferences or needs.

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 displayed. All chemicals are stored safely.

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.
---	--	--

A restraint policy includes restraint procedures. A documented definition of restraint and enablers is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. Staff are trained in restraint minimisation and safe practise. There were no residents with restraint and no residents with an enabler on the day of the 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. Information is obtained through surveillance to determine infection control activities.

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	17	0	1	0	0	0
Criteria	0	39	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaint forms. Information on the complaints forms includes the contact details for the Health and Disability Advocacy Service. Residents (five) and the relative are familiar with the complaints procedure and state any concerns or issues are addressed. The complaints register includes the date of the incident, complainant, response to complainant, and signature when the complaint is resolved. There have been no complaints received since the last certification audit in March 2016. The general manager informed that complainants are advised in writing of the outcomes of the investigations within the required timeframes. Advised that the three-monthly resident meetings are an open forum for residents to air any concerns or issues which are then dealt with in a timely manner.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Policies are in place relating to open disclosure. Five residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Twelve incident reports reviewed and associated resident files, evidenced recording of family notification. One relative interviewed confirmed that they are notified of any changes in their family member's health status. The general manager and clinical manager were able to identify the processes that are in place to support family being kept informed. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are</p>

<p>environment conducive to effective communication.</p>		<p>not covered by the agreement. The facility has an interpreter policy to guide staff in accessing interpreter 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>Holly Lea provides rest home and hospital (geriatric) care to up to 21 residents within a 38-apartment complex. On the day of audit, there were eight rest home level residents. There were no hospital level and no respite residents. All residents were under the age related residential care (ARRC) contract.</p> <p>The organisational structure includes a board made up of Generus Living Group personnel and previous members of the McLean Institute trust. The general manager reports to the Generus Living Group managing director. The general manager is a registered nurse (RN) and is experienced in aged care and management. The general manager has been in the role since December 2015 and has recently completed her master's degree in public health. The clinical manager commenced her role at Holly Lea in February 2016.</p> <p>The operational 2016 / 2017 business plan includes governance structure, financial management and budgets. The business plan identifies strategic priorities around development opportunities, industry engagement, market leverage 'best in class', value creation, organisational culture and business operations.</p> <p>The general manager and clinical manager have maintained at least eight hours of professional development in relation to management of a rest home.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The quality management manual includes the quality and risk management plan and service philosophy. The 2016 quality and risk management plan has been reviewed by the general manager and new goals and quality indicators have been set for 2017. The quality and risk management plan has documented aims and objectives. The internal audit schedule and internal audits are being completed. Corrective actions have been developed where compliance is less than expected and corrective actions evidence full completion. Staff meetings have been held with evidence of discussion of quality outcomes. Management meetings and resident meetings have also been held.</p> <p>The service collects information on resident incidents and accidents as well as staff incidents/accidents.</p> <p>The service has a health and safety management system and hazard registers are maintained. Security and safety policies and procedures are in place to ensure a safe environment is provided. There are reviewed, and current disaster and emergency management procedures and contingency plans are available for residents, staff and visitors in the event of specific emergencies/disasters (examples, flooding, earthquake, Tsunami, fire, unauthorised entry) and staff are informed about how to implement them. There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures. A resident and relative satisfaction survey (March 2016) has been conducted with respondents advising that they are overall very satisfied with the care and service they receive. A resident and relative satisfaction survey is due to be sent out in November 2017.</p>

		<p>There is an annual staff training programme implemented that is based around policies and procedures. Records of staff attendance and participation have been maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. The resident assessment policy and associated resident care planning policies include reference to the use of the interRAI assessment tool. This previously identified shortfall has been addressed. The general manager and clinical manager are in the process of reviewing all policies and procedures. There are procedures to guide staff in managing clinical and non-clinical emergencies. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</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>	FA	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and an analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. Either a RN or a healthcare assistant commences incident/accident forms. Progress notes reviewed for a sample of residents' evidence that all incidents and accidents had been reported. Follow-up by a RN was evident in twelve resident incident forms reviewed and corresponding residents' notes. Discussions with the general manager and clinical manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no requirements to complete any section 31 notifications since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the</p>	FA	<p>There are human resources management policies in place that includes recruitment and staff selection process. Policy requires that relevant checks be completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. The human resources policies also include orientation, staff training and development. Five staff files were reviewed (one clinical manager, one RN, one activities coordinator and two healthcare assistants) and evidenced that reference checks were completed before employment was offered. All files sampled had completed staff file documentation including staff appraisals.</p> <p>The service has in place an orientation programme that provides new staff with relevant information for safe work practice. Staff were able to describe the orientation process and stated that they believed that new staff were adequately orientated to the service. Discussion with the general manager, clinical manager and staff confirmed that in-service training has been provided since the previous audit. Training has included a healthcare assistant</p>

requirements of legislation.		online training programme and face-to-face sessions. There is an in-service calendar for 2017. The annual training programme exceeds eight hours annually.
<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>	PA Low	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The general manager and clinical manager work full time from Monday to Friday. There is one RN on duty on the morning shift and one RN on duty on the afternoon shift for three days (Sunday, Monday and Tuesday). The RNs are supported by an adequate amount of healthcare assistants. There are two healthcare assistants on duty on the morning and on the afternoon shifts, and two healthcare assistants on duty on the night shift. A roster provides sufficient and appropriate healthcare assistance to accommodate an increase in rest home resident occupancy and RN coverage for the effective delivery of care and support for on call 24/7. Hospital level care is not currently being provided. Therefore, the previous partial provisional finding around staffing coverage for hospital level residents has not yet been addressed. The clinical manager and RNs provide after hours on-call cover. Interviews with staff, residents and a family member, identified that staffing is adequate to meet the needs of residents.</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 healthcare assistants who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The staff administering medications complied with the medication administration policies and procedures as evidenced in the observed medication rounds. All medications were stored appropriately. Standing orders were current and reviewed annually by the GP. There were no residents self-medicating on the day of audit. All eye drops were dated on opening. The medication fridge is monitored daily. All ten medication charts reviewed 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</p>	FA	<p>The food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. All meals are prepared and cooked on-site by the catering manager and second cook. There was evidence of current food handling certificates. Residents are provided with meals that meet their food, fluids and nutritional needs. The registered nurse completes the dietary requirement forms on admission and provides a copy to the kitchen. The kitchen board is updated regularly. Additional or modified foods are also provided by the service. The service has a dietitian reviewed four weekly, four seasons menu.</p> <p>This is currently being updated with modifications following resident feedback. Fridge and food temperatures were monitored and recorded daily. Cooked meals are plated from the kitchen to the dining room. The meals were well</p>

<p>service is a component of service delivery.</p>		<p>presented, and residents confirmed that they are provided with alternative meals as per request. Resident satisfaction surveys confirmed general overall satisfaction with the meal service. All residents are weighed regularly. Residents with weight loss problems are provided with food supplements or referral to a dietitian.</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>In files reviewed care plan documentation was comprehensive. The interventions for managing acute health issues including wounds, were documented in short-term care plans. Files sampled demonstrated that interventions are updated when the desired goals/outcomes are not met or when the resident's response to the treatment is not satisfactory. Residents interviewed expressed satisfaction with the clinical care and that they are involved in the care planning. Healthcare assistants, a registered nurse and the clinical manager interviewed advised that there is adequate equipment provided including continence and wound care supplies. There were three skin tears recorded in the wound register. Wound assessment forms, and ongoing assessment and treatment forms were consistently completed for all wounds. Monitoring occurs for weight, vital signs, blood glucose and night checks.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Activities provided are appropriate to the needs, age and culture of the residents. The activities coordinator has adequate experience for the role and has a current first aid certificate and has commenced the diversional therapy apprenticeship programme. The activities programme is planned monthly in advance and a large print weekly activities programme is delivered to residents. Activities are planned over five days a week for a total of up to 26 hours per week to assist with the resident's preferred activities and interests. The resident's activities participation logs were sighted.</p> <p>There are a variety of activities that meet the abilities of all residents and to meet the physical, intellectual, sensory and social needs of the residents. Individual one-on-one time is spent with residents who choose not to join in group activities or are unable to participate in activities. A resident profile and activity plan is completed soon after admission in consultation with the resident/family and reviewed six monthly. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys and residents interviewed spoke positively of the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</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. Recent reassessments have been completed using the interRAI tool. The family are notified of GP visits and six-monthly reviews by phone call and if unable to attend, they are informed of all the changes.</p>

timely manner.		
<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>	FA	All chemicals sighted were appropriately stored and labelled in locked areas (including two sluice rooms). The previous partial provisional finding has been addressed around the safe storage of chemicals.
<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>	FA	The service displays a current building warrant of fitness, which expires on 1 November 2018.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	FA	The service has a current emergency/disaster management plan in place to guide staff in managing emergencies and disasters. There was an emergency/disaster management procedure available for staff, residents and visitors in the event of specific emergencies/disasters (including fire, earthquakes, floods, storms, tsunami and gas leaks). Staff interviewed were aware of the emergency procedures in place.

situations.		
<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>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered into an electronic database with healthcare solutions. A monthly infection summary provides data, which is monitored and evaluated monthly and annually. Outcomes and actions are discussed at management and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the general manager. Systems in place are appropriate to the size and complexity of the facility. No outbreaks have been reported since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The facility is restraint free. The clinical manager is responsible for restraint review and use, should this occur. There were no residents on restraint and no residents using an enabler on the day of the audit. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what restraint is and what an enabler is. Staff are trained in restraint minimisation and safe practise.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	The manager and clinical manager understand the requirement to employ and have available 24-hour registered nursing cover and sufficient care staff prior to the admission of any hospital level resident. There have not been any hospital level residents admitted and therefore this has not yet been required.	The current staffing cover is insufficient in the event that a hospital level resident(s) was admitted.	<p>Ensure adequate staffing provision is provided, including 24 hours/7-day registered nurse cover prior to the admission of a hospital level resident.</p> <p>Prior to occupancy days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.