

Lister Home Incorporated - Lister Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Lister Home Incorporated
Premises audited:	Lister Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 January 2018 End date: 30 January 2018
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:	61

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

Lister home and hospital is governed by a community trust board, comprised of representatives from all local churches in Waimate. The service provides care for up to 62 residents at hospital (geriatric and medical) and rest home level care. This includes one bed designated for respite care and one bed designated for palliative care. On the day of the audit there were 61 residents.

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

Lister Home and Hospital is managed by a nurse manager who is an RN and has been in the position for two years. The manager is supported by a registered nurse each shift and an enrolled nurse.

Residents, relatives and the GP interviewed spoke positively about the service provided.

This audit identified improvements required around quality documentation, training and neuro observations.

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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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The management team have an open-door policy. The personal privacy and values of residents are respected. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Families and friends are able to visit residents at times that meet their needs. 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 medium or high risk and/or unattained and of low risk.
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Lister home and hospital has a documented quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Incidents are documented and there is immediate follow-up from a registered nurse. There are human resources policies including

recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

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 nurse manager takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes.

Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

There are medication policies in place that comply with current legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed.

Meals are prepared on-site. The menu is developed under the direction of a dietitian and is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

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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The building has a current warrant of fitness and emergency evacuation plan. Ongoing and reactive maintenance issues are addressed. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is a main lounge and dining area, a library and other smaller seating areas. The internal areas are well ventilated and heated. The outdoor areas are safe and easily accessible. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster. There are emergency and disaster manuals to guide staff in managing emergencies and disasters.

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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The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. At the time of the audit there were six residents who have a bedside rail and two lap-belt restraints and one resident using an enabler (bedside rails). Staff training is in place around restraint minimisation and management of challenging behaviours.

Infection prevention and control

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



Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to the board in a timely manner. There have been no outbreaks.

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	47	0	2	1	0	0
Criteria	0	97	0	2	1	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with nine care staff (four caregivers, two registered nurses (RN), one enrolled nurse (EN) and two diversional therapists (DT) confirmed their understanding of the Code. Nine residents (seven rest home and two hospital level) and two relatives (rest home level) interviewed, confirmed that staff respect privacy and support residents in making choices.</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</p>	FA	<p>The service has policies and procedures relating to informed consent and advanced directives. All eight resident files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted, which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.</p>

informed consent.		
<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	Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy information is available in reception. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on resident's family/whānau and chosen social networks.
<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	Residents and relatives interviewed confirmed open visiting hours. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.
<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	The complaints procedure is provided to resident/relatives at entry and is prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. There have been two complaints made over 2017. Documentation, including follow-up letters and resolution, demonstrated that complaints are well managed. Discussion with residents and relatives confirmed they were provided with information on complaints, and complaints forms
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	An information pack given to prospective residents and families includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with</p>	FA	Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that align with policy. Relatives interviewed confirmed that staff treat residents with respect. Resident preferences are identified during the admission and care planning process and include family involvement. Caregivers could describe

respect and receive services in a manner that has regard for their dignity, privacy, and independence.		<p>how choice is incorporated into resident cares.</p> <p>Caregivers have had training around recognition and prevention of abuse and neglect and actions they should take if this is identified. Caregivers interviewed could describe appropriate processes around this.</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>There is a documented Māori health plan policy for the service that includes recognition of Māori values and beliefs. The service has links to a local runanga and the Māori liaison person at the DHB. The local Kapa Haka group also use the services meeting room for practices. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. During the audit, there were no residents that identified as Māori living at the facility.</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 ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met, family/whānau are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process includes the signing of house rules and a service code of conduct. Staff job descriptions include responsibilities. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy, and boundaries. Interviews with staff confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Policies and procedures have been reviewed two yearly. These were available in hard copy. A variety of staff meetings and residents' meetings have been conducted. Residents and relatives interviewed spoke very positively about the care and support provided.</p> <p>Staff had a sound understanding of principles of aged care and stated that they felt supported by management. Evidence-based practice is evident, promoting and encouraging good practice. A physiotherapist is available for three hours per week and an occupational therapist, ten hours a week.</p>

		<p>There is an education and training programme for staff. The service encourages residents to remain independent.</p> <p>The service works to maintain and enhance equipment with eight new mattresses and a trolley bath recently purchased. They are also trialling ceiling hoists. Residents and caregivers interviewed were very complementary about the ceiling hoist.</p> <p>Lister Home and Hospital residents continue their community links when admitted, for example one resident is a member of the probus club, and others attend senior citizens, women's institute, and bowls. Family, friends and neighbours are also encouraged to continue with routines they had before admission (i.e., one resident has lunch with her old neighbours every Friday). Community members regularly drop various items in, such as flowers for vases, magazines, baking and produce. Lister Home and Hospital and the residents, are considered a big part of the community and are included in community events (e.g., motorbike rallies the bikers call into the service to show residents their bikes).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident/accident into the system. Ten incident/accident reports reviewed met this requirement. Relatives interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.</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>Lister Home and Hospital is governed by a community trust board, comprised of representatives from all local churches in Waimate. The service provides care for up to 62 residents at hospital (geriatric and medical) and rest home level care. This includes one bed designated for respite care and one bed designated for palliative care and up to seven dual-purpose beds.</p> <p>On the day of the audit, there were 61 residents in total - 37 at rest home level (including two under mental health contracts) and 24 hospital level (including one palliative, one respite and one younger person on a disability contract).</p> <p>The service has a strategic plan, a quality and risk, and a risk and management plan documented. Organisation goals are documented and reflect the philosophy of this Christian based organisation</p> <p>Annual goals are documented and reflect regular reviews via regular meetings. The nurse manager reports to the board monthly, against the quality and risk plans and on a variety of operational issues.</p> <p>Lister Home and Hospital is managed by a nurse manager who is an RN and has been in the position</p>

		for two years. The manager is supported by an RN each shift and an enrolled nurse. The nurse manager has completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months.
<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>	FA	A senior registered nurse provides cover during the temporary absence of the nurse manager.
<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>	PA Low	<p>Lister Home and Hospital has a documented quality and risk management system. The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Policies are current, and staff are informed of updates and changes.</p> <p>The service has a series of meetings in place as part of the quality and risk process. These include monthly RN meetings and two monthly quality meetings. Meetings document that a variety of clinical and operational issues are discussed. Key components of the quality management system were not documented as discussed, to the quality meetings or clinical/RN meetings.</p> <p>The overall service result for the resident/relative satisfaction survey completed in 2017 reflected 'good' services. There is an internal audit schedule in place, but this was not always documented as followed. Action plans were documented where areas of non-compliance were identified. There are a series of kitchen audits documented where a high level of non-conformance was found. The subsequent action plan(s) included an external consultant who was brought in to assist maintaining standards. Continued audits and discussion with the nurse manager evidence that the issue has been rectified.</p> <p>There are monthly accident/incident and infection reports provided and these are displayed in the staff room. There is a hazard management, health and safety, and risk management programme in place. There are facility goals around health and safety. The health and safety officer was interviewed. There is a designated health and safety committee who meet as part of the quality meetings. There is a current hazard register. Falls prevention strategies are in place including intentional rounding, post falls reviews and individual interventions.</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>The service documents and analyses all incidents/accidents. All incident forms are reviewed and collated monthly. A trend analysis and report are provided to the board monthly, and also posted on the staffroom noticeboards (link 1.2.3.6). Ten resident related incident/accident forms were reviewed. Individual incident reports have been completed for each incident/accident, with immediate action noted and individual resident risks were documented as followed up. The incident/accident forms reviewed documented immediate follow-up by a RN including completion, and neurological observations were not documented for all unwitnessed falls or falls with a possible head injury (link to 1.3.6.1). Discussions with the nurse manager, confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There had been three section 31 notification made from 2017 relating to: a call bells failure (which has been fully rectified), RN night cover, which has been fully resolved (November 2017) and an unstageable PI for a palliative resident (October 2017).</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 requirements of legislation.</p>	<p>PA Moderate</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Ten staff files were reviewed (one RN, one enrolled nurse, four caregivers, one housekeeper, one diversional therapist and two cooks). All files included appropriate employment documentation and up-to-date performance appraisals. A register of practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice, including caring for those with dementia. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>An annual education schedule for 2017-2018 is being implemented but does not cover all compulsory subjects and first aid certificates are not all up-to-date. Additional training is provided as needed. Registered nurses (RNs) are provided with RN specific training (such as NikiT for example).</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>The staffing policy aligns with contractual requirements and includes skill mixes. The chief nurse manager works 40 hours per week and shares the 24/7 on-call duties with the senior nurses. All areas of the service are on one floor and in close proximity.</p> <p>The hospital staffing (up to 34 residents) includes; an RN each shift with an additional RN, two days a week. Caregiver staffing included AM two long and four short-shifts, PM two long and three short-shifts and one caregiver at night.</p> <p>The rest home wing staffing (up to 28 residents) includes; an enrolled nurse for the day shift Monday to Friday, caregivers include: AM one long and three short-shifts, PM one long and two short-shifts and one</p>

		<p>caregiver at night. The nurse manager and RN from the hospital provide oversight to the rest home. (Link to 1.2.7.5 as not all shifts currently have a qualified first aider rostered).</p> <p>Interviews with relatives and residents all confirmed that staffing numbers were appropriate. Caregivers interviewed stated that they have sufficient staffing levels.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service had all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files were located in the nurses' station. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries were legible, dated and signed by the relevant staff member.</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>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. Eight signed admission agreements were sighted. The admission agreement form in use aligns with contractual requirements.</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>The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and 'the yellow envelope' is used. The RNs report that they include copies of all the required information in the envelope.</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</p>	FA	<p>Sixteen medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. The service uses an electronic medication management system for long-term residents of the house doctor and paper-based records for other residents. The medication charts reviewed identified that the GP had seen and reviewed the resident at least three-monthly.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses and an enrolled</p>

<p>guidelines.</p>		<p>nurse interviewed could describe their role regarding medication administration. Administration records demonstrated that not all medications were administered as prescribed. The service currently uses a robotic roll system for medications. Blister packs and non-packaged medications are checked on delivery against the medication charts. There are weekly medication checks as needed.</p> <p>Standing orders are in use and documented according to set guidelines, and indications of use for each PRN medication are documented. There were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperature is recorded regularly and is within the acceptable ranges.</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>	<p>FA</p>	<p>All meals at Lister Home and Hospital are prepared and cooked on-site. They are transported to the smaller dining rooms and lounges in hot boxes from which the staff serves the meals. There is a serve yourself meal service in the main dining room, which residents are encouraged to help themselves. There is a four-weekly seasonal menu. A consultant recently assisted with the kitchen due to concerns over cleanliness. There is a verified food control plan, completed by the local council. The kitchen staff were aware of all resident's special dietary requirements on the day of audit. The cook is aware if residents are losing weight or not enjoying meals and she discusses with them or their families what food they would prefer, and this is provided. Individual resident likes, and dislikes are accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were very complimentary about the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End-cooked food temperatures are recorded daily. The dishwasher is checked regularly by the chemical supplier. Fridge temperatures are recorded for the fridges in each resident dining/servery area.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety.</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</p>	<p>FA</p>	<p>The reason for declining service entry to prospective residents to the service is recorded. Should this occur, the manager stated it would be communicated to the potential resident/family/NOK and the appropriate referrer. Potential residents would only be declined if there were no beds available or if they could not meet the service requirements.</p>

and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Eight of eight files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident, NOK and their relatives where appropriate. Eight of eight files sampled contained appropriate assessment tools that were completed and in long-term files, assessments that were reviewed at least six monthly or when there was a change to a resident's health condition. The interRAI assessment tool is implemented. Two of the five registered nurses and one of one enrolled nurses are interRAI trained. InterRAI assessments have been completed for all long-term residents.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement. The service has a number of care plans in use (e.g., nursing care plan, lifestyle plan, short-term care plan, and wound care plan). The care plans reviewed were resident focused. The interRAI assessment The respite resident at rest home level (file reviewed) included all information to guide care process informs the development of the resident's care plan. Residents and their family/NOK interviewed, reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	A written record of each resident's progress is documented. Resident changes in condition are followed-up by a registered nurse as evidenced in residents' progress notes. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. In the files reviewed, short-term care plans were evidenced following a change in health condition and linked to the nursing care plan documents. There was evidence in the files sampled of referral for specialist advice. Action plans documented by allied health practitioners had been implemented or documented in the nursing care plans. Dressing supplies are available. Wound care documentation was reviewed for five residents with ten minor wounds (one resident had five wounds) and two residents with pressure injuries. Wound care assessments, plans and reviews including photographs were documented for all wounds and there was evidence of GP involvement in the management of wounds. Continence products are available and resident files include a urinary continence assessment, bowel

		<p>management, and continence products identified. Registered nurses could describe access to continence specialist input as required.</p> <p>Monitoring forms are in use by the registered nurses. Forms sighted included monthly blood pressure and weights, pain monitoring, nutritional and food monitoring and behaviour monitoring and turning charts.</p> <p>Neuro-observations are not recorded following unwitnessed falls and falls involving head impact.</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>	FA	<p>There are two diversional therapists, one who works 13 hours a week and the other who works 29 hours a week. There are an additional two activity coordinators who cover annual leave and weekends. This is supported by volunteers. A wide range of activities addressing the abilities and needs of different residents (rest home, hospital and activities aimed at a younger group) are offered and the attendance rate is high with residents of different abilities being supported to enthusiastically join in the activities.</p> <p>A wide range of group activities are offered, many at the suggestion of residents. There is also significant engagement with the community including outings to clubs and concerts, farm visits and a variety of groups, and individuals from children to older people visit the service.</p> <p>Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing.</p> <p>On admission, the diversional therapist completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.</p> <p>Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement. The diversional therapist has a current first aid certificate.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses and enrolled nurse evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term nursing care plan was evaluated at least six-monthly or earlier if there is a change in health status. There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents and/or their family/NOK are involved as appropriate when a referral to another service occurs. Registered nurses and enrolled nurse interviewed described the referral process should they require assistance.</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>	FA	<p>The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed.</p> <p>Chemicals were secured in designated locked cupboards. Chemicals were labelled, and safety datasheets were available throughout the facility and accessible to staff. Safe chemical handling training has been provided. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties.</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>	FA	<p>The building has a current building warrant of fitness which expires on 1 August 2018. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. There are outside areas with seating, tables and shaded areas that are easily accessible. Staff stated they had 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</p>	FA	<p>There is a combination of resident rooms with full ensuite bathrooms and those without. There are sufficient communal bathrooms and toilets to accommodate the needs of other residents. The ensuites and communal toilet facilities have privacy locks. One communal bathroom was being refurbished on day of audit. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>

or receiving assistance with personal hygiene requirements.		
<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	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms, and this has occurred.
<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 relaxation, activity, and dining needs.</p>	FA	There is a large communal lounge and dining area that is well used and seven smaller lounges, which double as small dining areas in each wing. There is also a library lounge. Furniture is appropriate to the setting and arranged in a manner, which enables residents to mobilise freely. The main lounge is used for activities and a specific area for the hairdresser. The outdoor courtyards are also used for activities such as resident raised gardens and walking.
<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>	FA	<p>Dedicated cleaning staff are rostered on seven days per week. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme.</p> <p>The laundry is all completed on-site, and dedicated laundry staff are rostered on seven days per week. Laundry and cleaning staff interviewed advised that they had received training in chemical safety, infection control and waste management.</p> <p>Cleaning products and laundry products are well labelled and kept in securely locked cupboards and chemical safety data guidelines are available.</p> <p>The laundry and cleaning service has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Residents interviewed were satisfied with the standard of cleanliness in the facility and the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	FA	<p>The service has an approved fire evacuation plan, dated 29 October 1993. Fire evacuation drills occur six monthly, with the last drill occurring on 12 October 2017.</p> <p>Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking</p>

Consumers receive an appropriate and timely response during emergency and security situations.		facilities (BBQ) available in the event of a power failure. There is a back-up generator and diesel fuel supplies to run this. There are civil defence kits in the facility and sufficient stored water. Call bells are evident in residents' rooms, lounge areas, and toilets/bathrooms. The facility is secured at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature.
Standard 3.1: Infection control management 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.	FA	Lister has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Lister KPIs. A registered nurse is the designated infection control nurse with support from the nurse manager. The quality meeting team is the infection control team. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	A registered nurse at Lister is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention	FA	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The comprehensive policies have been developed by an external service

and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		and have recently been fully implemented at Lister.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Education is facilitated by the infection control nurse with support from the nurse manager. All infection control training is documented, and a record of attendance is maintained.
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	Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections were entered onto a monthly facility infection summary (link to 1.2.3.6). This data is monitored and evaluated three monthly and annually. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. At the time of the audit there were six residents who have a bedside rail and two lap-belt restraints and one resident using an enabler (bedside rails). Staff training is in place around restraint minimisation and management of challenging behaviours.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint	FA	The restraint approval process is described in the restraint minimisation policy. An RN is the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.

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.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/NOK. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family are evident. Three resident files where restraint was in use, and one resident with an enabler was reviewed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Monitoring is documented on a specific restraint monitoring form, evidenced in the one resident file where restraint was being used. A restraint register is in place providing a record of restraint and enabler use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint evaluations are conducted monthly and restraint use is discussed monthly at both the RN and staff/quality meetings. A review of three resident files identified that evaluations were up-to-date.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint minimisation programme is discussed and reviewed at the six-monthly organisation-wide restraint coordinators meetings, monthly RN meetings and monthly staff/quality meetings. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education/training.

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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	The service has implemented a series of meetings where a variety of operational issues are discussed including: two monthly quality meetings, monthly RN meetings, special meetings (such as the garden group) and annual general meetings. Quality data is not consistently reported at meetings. There is a quality and risk system documented for the service that includes a schedule of internal audits. Not all audits are documented as undertaken, as planned	(i)Quality data is not consistently documented as discussed at the two monthly quality meetings or monthly RN meetings. Examples include falls, infection control, restraint, incident and accidents and survey results. (ii) Internal audits are not always documented as undertaken as per schedule, examples include: care plan audits (August 2017), cleaning audits, and resident care audits for April and August 2017	(i)Ensure that meetings document that quality data and trends are documented as discussed at meetings. (ii) Ensure that internal audits are undertaken as per schedule 60 days

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>The service has set education days twice a year for all staff. This is a paid day set aside for staff to attend a variety of compulsory education subjects, and additional training is also provided over the year. Not all compulsory subjects have been provided over the last two years. Not all staff leading shifts have an up-to-date first aid certificate (training has been booked).</p>	<p>(i) Not all compulsory training is documented as provided, examples include; pain, documentation and continence. (ii) First aid certificates are out-of-date for many staff and this has led to eight of twenty-one shifts over the last week not having a qualified first aider.</p>	<p>(i) Ensure training is delivered as per training plan. (ii) Ensure that each shift has a qualified first aider rostered.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Eight resident files reviewed all had care plans in place. Monitoring forms are in use by the registered nurses. Forms sighted included monthly blood pressure and weights, pain monitoring, nutritional and food monitoring and behaviour monitoring and turning charts. Incident forms were documented for all identified falls and post falls interventions were in place however, one resident who had experienced a head impact caused by a fall had no documented records of neuro-observations.</p>	<p>One resident who had a fall, which resulted in a head impact, did not have neuro-observations recorded.</p>	<p>To ensure neuro-observations are completed and documented for any resident who experiences an unwitnessed fall or head impact caused by a fall.</p> <p>60 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.