G J & J M Bellaney Limited - Wimbledon Villa

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:	G J & J M Bellaney Limited
Premises audited:	Wimbledon Villa
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 28 March 2018 End date: 29 March 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: 31

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

Wimbledon Villa provides rest home, dementia and hospital (geriatric) level of care for up to 38 residents. On the day of the audit, there were 31 residents.

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, relatives, staff and management.

The business manager is appropriately qualified and experienced and is supported by a clinical nurse manager.

The service has addressed the six shortfalls from their previous partial provisional and certification audits around registered nurse cover, medication room size, completions of renovations and entrance for the hospital, incident reporting and restraint documentation and management.

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.

Residents and family are well informed, including of changes in resident's health. Management have an open-door policy. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The quality and risk management programme includes service philosophy, goals and a quality planner. Meetings are held to discuss quality and risk management processes. There is a health and safety management programme available to guide staff. Resident/family meetings are held monthly. Incidents and accidents are reported. There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme for 2018 is in place. A roster provides sufficient and appropriate coverage for the effective delivery of 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. The residents and family interviewed confirmed their input into care planning. A sampling of residents' clinical files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan. There is an appropriate medicine management system in place.

Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme and their ability to have it changed if desired. Individual activities are provided either within group settings or on a one-on-one basis. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. Provision of the food service is provided by in-house staff.

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.

The building has a current warrant of fitness.

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.

Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit, there were no residents with restraint and no residents using enablers. Staff training has been provided 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.

Wimbledon Villa has an infection control programme that complies with current best practice. The infection control programme is designed to link to the quality and risk management system. Records of all infections are kept and provided to a contracted service for benchmarking.

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	18	0	0	0	0	0
Criteria	0	43	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Information about complaints is provided on admission to residents and their families/whānau. Feedback forms are available for residents and families/whānau in various places around the facility. All staff interviewed were able to describe the process around reporting complaints. There is a complaint's register. Two complaints have been made in 2017 and one in the year-to-date. All complaints reviewed had written investigations, timeframes and where required, corrective actions were documented and implemented. Results and outcomes of the investigations are fed back to complainants. Discussions with residents/relatives confirmed that any issues are addressed, and they feel comfortable to bring up any concerns.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Five relatives (one hospital, three dementia and one rest home) and two rest home residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Ten incidents/accident forms reviewed include a section to record family notification. All forms evidenced family were informed if they wished to be. Five relatives (hospital, dementia and rest home) interviewed, confirmed that they are notified of any changes in their family member's health status. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.

conducive to effective communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Wimbledon Villa provides care for up to 38 residents at hospital, rest home and dementia level care. On the day of the audit, there were 31 residents in total, five residents at rest home level, seven residents at hospital level (including one respite) and 19 dementia level residents. All rest home/hospital beds are identified as dual-purpose. The proprietors have overall financial and governance responsibility (not based on-site) and there is a strategic business plan in place. The business plan and goals are developed in consultation with the business manager and clinical nurse manager and include the goal of meeting all standards of care, fully. The business manager (non-clinical) has been in the role for some years. The business manager is supported by a clinical nurse manager who has been in the role for four years and has considerable background in aged care. The clinical nurse manager and business manager have attended at least eight hours of professional development relevant to the role.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is a documented quality and risk management system. The content of the policies and procedures is detailed to allow effective implementation by staff. The services policies are reviewed annually. The quality and risk management system is designed to monitor contractual and standards compliance and includes schedules for training and audit requirements for the month and the managers and quality control officer ensure completion of these requirements. The internal audit programme had been implemented and corrective action plans were completed and signed off for internal audits that were not compliant. There are monthly accident/incident benchmarking reports completed by the quality control officer that break down the data collected across the rest home, dementia, hospital and staff incidents/accidents. Infection control is also included as part of benchmarking. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in September 2017 was at 83%. Corrective actions were undertaken. There is a health and safety and risk management programme in place including policies to guide practice. The diversional therapist is the health and safety officer (interviewed) and had completed the specific health and safety training requirements. Health and safety internal audits are completed. There is a meeting schedule including monthly staff meetings that include the quality meeting and health and safety meeting and also includes discussion about clinical indicators (e.g., incident trends, infection rates and health and safety). Registered nurse/clinical nurse manager meetings are held fortnightly. The CNM and business manager have a documented meeting three monthly.

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. On interview staff understood what an accident and incident was and actions to be taken. The nature/range of accident and incidents included in the forms reviewed, indicated that accidents and incidents were appropriately being reported. The previous finding has been addressed. Ten accident/incident forms were reviewed for February/March 2018. Each event involving a resident, reflected a clinical assessment and follow-up by a registered nurse (RN). Data collected on incident and accident forms (in the process of loading onto an electronic system) are linked to the quality management system. Discussions with the clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been six events since the last audit that triggered a section 31 notification.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies to support recruitment practices. Five staff files reviewed, including one RN, one cook, one diversional therapist and two caregivers evidenced employment contracts and completed orientation. A register of registered nursing staff and other health practitioner practising certificates is maintained. Recruitment, qualifications, orientation training, performance management information is available on-site for staff. The orientation programme includes documented competencies and induction checklists. There is an annual education plan for 2018. In 2017, the education plan had been completed. Core competencies are completed, and a record of completion is maintained on staff files. The service has five of eight RNs trained in interRAI. There are 14 caregivers that work in the dementia unit. Ten caregivers have completed the required dementia standards. The other four caregivers are currently undertaking the training with careerforce.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from	FA	There is a safe staffing policy and procedure, which describes staffing, and this can be increased if resident acuity demands. The business manager and clinical nurse manager both work 40 hours per week from Monday to Friday and are available on call for any emergency issues or clinical support. The clinical nurse manager works 40 hours per week from Monday to Friday. The service has increased the number of registered nurse hours and now employs seven registered nurses as well as the CNM and provides 24-

suitably qualified/skilled and/or experienced service providers.		hour RN cover. The previous partial provisional audit finding has been addressed. In the dementia unit (19 residents) there is one RN and two HCAs on duty on the morning shift, three HCAs (one from 4.30 pm to 8.30 pm) on duty on the afternoon shift and one HCA on duty on the night shift. In the rest home/hospital (5 rest home, 7 hospital) there is an RN on morning and afternoon shift along with an HCA. On night there is a RN on plus a HCA that floats between the two units. Staff sickness and vacant shifts are covered. Five caregivers interviewed confirmed that staff are replaced. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. RNs and senior HCAs are responsible for the administration of medications in the rest home/hospital and dementia care unit. Senior HCAs complete competencies for the checking and witnessing of medications as required. Medication competencies and education has been completed annually. All medications delivered were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. The service has an electronic medication system. There were no residents self-medicating on the day of audit. Ten resident medication charts on the electronic medication system were reviewed. The charts had photograph identification and allergy status recorded. Indications for use were documented in all charts reviewed. The medication system is audited six monthly and any findings are corrected (last audit December 2017). All 10 medication charts reviewed identified that the GP had reviewed the medication chart three monthly (including the respite resident). Alterations had been completed to enable the safe storage and working space for medication management in the rest home/hospital. The finding from the partial provisional audit had been addressed.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a	FA	All meals are cooked on-site. There is a four-week rotating seasonal menu approved by the dietitian. The chef is supported by a cook and a kitchenhand. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. The kitchen is adjacent to the dining room of the dementia unit and meals are served directly to this unit. Meals for the rest home/hospital unit are plated in the kitchen and transferred in an insul box to the unit kitchenette. The cook receives a dietary profile for each resident and these are updated as required. The chiller and freezers have daily temperatures recorded. End cooked food temperatures are recorded. All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. There is a food safety plan which is booked for validation April 2018.

component of service delivery.		Staff working in the kitchen have food handling certificates and chemical safety training. Residents and relatives commented positively on the meals provided. The chef welcomes feedback on the meal service. Snacks are available for residents in the dementia unit 24/7.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required a GP. There is documented evidence where care plans have been updated to reflect the changes in resident needs/supports. Short-term care plans are developed for infections, wounds, challenging behaviour and acute changes. Five resident files reviewed, included interventions to support residents current assessed needs. One resident had a short-term behaviour management plan, one a PI short-term care plan and one resident with weight loss had interventions documented. There was a clear link between GP notes, allied health notes and the current care plan. Monitoring forms in place include (but are not limited to); monthly weight, blood pressure and pulse, food and fluid charts, change of position and behaviour. Progress notes document changes in health and significant events. Residents and relatives confirm their expectations are met and they are kept informed of any changes to health. A sample of five wounds were reviewed during the audit including (one grade one PI, three skin tears and one trauma). All wounds included a wound assessment and treatment plan and regular evaluations have been completed. The RNs have access to specialist nursing wound care management advice if required. Adequate dressing supplies were sighted in the treatment room. Continence products are available and resident files include a continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the	FA	The service employs a diversional therapist (35 hours per week, Monday to Friday). There are also two volunteers for 40 hours a week between them, Monday to Friday and some Saturdays. The programme provides activities that are meaningful and relevant for all residents. Time is spent with residents and families to further explore their individual life goals and to aid development of new and meaningful activities. Rest home and hospital residents join together for the activity programme. Participation of residents is monitored and documented. There is a separate activities programme for the dementia unit and when appropriate they join with the RH and hospital activities. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community (the facility has a van and they also hire in a disability van weekly), entertainers three times a week (including Saturday) and weekly pet visits. Daily contact is made, and one-on-one time is spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme.

service.		The diversional therapist meets with other local recreational/diversional therapists monthly. The activity programme is developed in advance and a calendar is displayed throughout the facility. The activity plans reviewed were well documented and reflected the resident's preferred activities and interests. Each resident has an individual activities assessment on admission and from this information, an individual activity care plan is developed. The activities plans were reviewed six-monthly. Residents and families interviewed stated they enjoy the variety of activities offered and they have input into planning of the programme via daily feedback, resident surveys and at resident meetings. They reported that they had requested more activities geared towards male interests and changes were being made to accommodate this.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations describe the resident's progress against the resident's (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The GP reviews residents at least three-monthly or when there is a change in health status. The family members interviewed confirmed they are invited to attend the GP visits and multidisciplinary care plan reviews.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness which expires on 8 July 2018. Renovations had been completed making a reception/administration area for the nursing staff and the safe storage of resident files. There is a call button for visitors to seek assistance. The previous partial provisional finding has been addressed.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency	FA	Renovations had been completed making a reception/administration area for the nursing staff and the safe storage of resident files. The service consulted with the fire service at the time of the renovations and it was confirmed that no updates to the fire evacuation procedure was needed. Six monthly fire drills have occurred. There is a first aider with a current certificate on duty 24/7. Since the previous audit the service has also had training around fire safety and earthquake response.

and security situations.		
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	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and DHB infection control nurse that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Surveillance data is available to all staff. Infection statistics are included for benchmarking via the contracted benchmarking system and infections are reviewed at the fortnightly registered nurse meeting. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register and an item on infection control is put in the bi-monthly resident/relative newsletter.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The policies and procedures include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraint and no residents using enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours (September 2017). Restraint audit last completed November 2017, 100%.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	There were no residents restrained or using enablers on the day of audit. The file of the last resident restrained was viewed (a post-surgical resident requiring restraint to aid healing for 1.5 weeks) was viewed and all aspects of the criterion were complied with. Staff interviewed understood what restraint was and associated safety issues. The previous finding has been addressed.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.