Glenlaurel Care Limited - Lexham Gardens Rest Home

Introduction

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

The audit has been conducted by The DAA Group 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:	Glenlaurel Care Limited
Premises audited:	Lexham Gardens Rest Home
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 May 2018 End date: 23 May 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: 49

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

Lexham Gardens Rest Home (Lexham Gardens) provides rest home, geriatric hospital level care for up to 50 residents. The service is operated by Glenlaurel Care Limited and managed by a facility manager and a clinical manager. Residents and family/whanau spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service`s contract with the district health board. The audit process included review of policies and procedures, review of residents` and staff records, observations and interviews with residents, family members, management, staff and a general practitioner.

The audit resulted in no areas being identified as requiring improvement. The one area from the previous audit related to self-administration of medicines has been addressed.

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.

Open communication between staff, residents and families is promoted and was confirmed to be effective.

The complaints register is maintained with complaints being resolve promptly and effectively.

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.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of service provision is completed regularly. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies any trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risk, are identified. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on efficient processes and good practice. Training and education supports safe service delivery and includes regular performance review. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

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

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that meet the needs of the residents.

Residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident's needs, a short-term plan is developed and integrated into a long-term plan, as needed. All long-term care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs and interests of the residents as individuals and in group settings.

The onsite kitchen provides and caters for residents. Specific dietary likes and dislikes are accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met. A food safety plan has been submitted for approval.

An appropriate medicine administration system was observed at the time of audit. A staff competency assessment, and a resident assessment to ensure safety to self-administer medicines, is in place.

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 which is displayed in the entrance to the facility.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Enabler use is voluntary for the safety of residents in response to individual requests. Eight restraints were in use. Restraint is only used as a last resort when all other options have been explored. Staff interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.

Surveillance for infections is undertaken monthly. Results of surveillance are analysed to assist in promoting infection prevention and reduction. The surveillance results are appropriately reported to staff and management in a timely manner. The surveillance programme is appropriate to the service setting.

Summary of attainment

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

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

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The compliment/complaint policy and associated forms meet the requirement of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and family on admission and there is complaints information and forms available in several areas in the facility. The complaints register reviewed showed that four verbal and two written complaints have been received since the previous audit and that actions were taken through to an agreed resolution. The documentation was followed through and all was completed within the timeframes specified in the Code. Action plans reviewed showed any required follow-up and improvements have been made where possible. The manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide	FA	Residents and family members stated they were kept well informed about any changes to their/their relative`s health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents` records reviewed. Staff understood the principals of open disclosure which is supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services although reported this was rarely required due to most residents being able to communicate effectively in English. There are communication strategies in place for residents with

an environment conducive to effective communication.		cognitive impairment or who have non-verbal means of 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	The Business Plan 2018 – 2019 sighted was reviewed annually. The plan outlines the purpose, values, scope, direction and goals of the organisation over a five year period, and also highlights the goals for one year. The mission statement for the organisation is displayed at the entrance to the facility. A sample of reports to the facility manager showed the information required was being reported on as requested and was followed up at the quality and staff meetings by the facility manager. The facility manager reports to two other co-directors. The service is managed by a facility manager who holds relevant management qualifications and has been in the role since 2015. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency by attending related business courses. The facility manager also attends meetings/training/updates in the aged residential care sector regularly. The service holds contracts with the Auckland District Health Board (ADHB) for up to 50 residents. On the day of audit there are 16 rest home level care residents and 33 geriatric hospital level care residents.
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	Glenlaurel Care Limited has reviewed and implemented all required policies and procedures. Any new and/or draft policies requiring consultation are managed by the facility manager with staff consultation as required. All legislative requirements are effectively met. Any obsolete documents are stored appropriately in a locked room. An archive system is utilised and records can be retrieved as needed. The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement and is understood by staff. This includes the management of incidents and complaints, audit activities, an annual resident/family survey, monitoring of outcomes, clinical incidents including restraint minimisation and safe practice. Infection control and health and safety are closely linked with the quality and risk programme. Terms of reference and meeting minutes reviewed confirmed more than adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of key quality indicators occurs and related information is reported by the clinical manager to the facility manager. Information is discussed at the quality/staff meetings. Minutes of meetings reviewed included a set agenda and evidence that all clinical indicators are discussed. Relevant corrective actions are developed and implemented to address any shortfall and demonstrated a continuous process of quality improvement is occurring. Staff interviewed reported their involvement in quality and risk management activities through the internal audit activities that they are involved with each month or as required.

		The facility manager described the process for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register showed consistent review and updating of risks, risk plans and addition of any new risks identified. The register was reviewed and updated on the 26 April 2018. The facility manager is aware of and attends training as the health and safety officer on the Health and Safety at Work Act (20015) requirements and has implemented requirements.
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	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is collated by the clinical manager, analysed and reported to the facility manager/staff. Meeting minutes showed discussion in relation to outcomes of any trends identified, action plans and improvements made. Comparisons are made with previous months and the previous year by the clinical manager. Policy and procedures clearly described essential notification reporting requirements. The clinical manager advised there have been three notifications events made to HealthCERT since the previous audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Policies and procedures reviewed are in line with good employment practice and relevant legislation. The policies guide staff on all aspects of human resources management processes. Position descriptions reviewed were current and defined key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation`s policies are being consistently implemented and records are systematically maintained.  Staff orientation/induction includes all necessary components relevant to each role. Staff reported that the orientation process prepared them well for their role and included support from a `buddy` through the initial orientation period. Staff records reviewed showed documentation of completed orientation and appraisals are completed. Continuing education is planned two yearly for contractual obligations and annually for all other topics and mandatory training is included. Healthcare assistants are completing a New Zealand Qualifications Authority education programme (Careerforce) to meet the requirements for the provider`s agreement with the DHB. Five healthcare assistants are currently completing level 2, one level 3, three staff have level 4 and one health care assistant has Level 4 (Diversional Therapy). Education records reviewed demonstrated completion of the required

		training. Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs, supervision requirements and review competencies. Appraisals were current for all staff.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a policy on staffing levels and skill mix which describes the rationale for staffing this facility to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of residents. The minimum number of staff provided is on the night shift with one registered nurse and two health care assistants. An after-hours on call roster is in place with staff reporting that good access to advice is available when needed. Healthcare assistants reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a four-week roster cycle sample during the audit confirmed adequate staff cover has been provided. The service does not employ bureau staff. There is a staff member with a first aid certificate on each duty. There is registered nurse coverage twenty-four hours a day seven days a week.
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	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management (using a paper-based system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer, or check medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. A RN checks medication against the prescription on arrival. All medications sighted were within current use by dates. A small supply of impress medicines is available on site for hospital level care residents. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks, accurate entries and quantity-controlled counts undertaken at the bottom of each page. The records of temperatures for the medicine fridge and specimen fridge reviewed were within the recommended range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and requirements for pro re nata (PRN) medicines met for 18 out of 20 patients' files sampled. Two patients did not have the rationale for PRN laxatives detailed. This is not raised as an area for improvement as it did not reflect a systemic issue, as indications were noted for the vast majority of medicines charted. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders

		are not used. There were four residents who were self-administering medications at the time of audit. Detailed assessments have been conducted with these residents in the last three months. The GP has approved the residents as appropriate to self-administer their inhalers. A patient who self-administered inhalers stated he 'had managed this aspect of medicine for over 40 years and was more than capable of continuing'. The patient advised the medicine is stored securely in a designated drawer. The shortfall from the last audit has been addressed. Documentation identifies that residents and family members are informed of proposed or actual changes in medicines including the commencement of short course treatment for infections or other issues. There is an implemented process for the reporting and analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by one of two cooks, and kitchen assistants', with the support of the health care assistants, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in January 2018. The winter menu is in use. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service has partnered with other aged residential care services in developing a group food safety plan. Emails sighted verified the food safety plan has been submitted to the regulatory authority for approval and is currently under review. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of daily food services. The cooks and kitchen assistants have completed relevant food handling training, with certificates displayed in the kitchen. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. These plans are revisited as the care needs of the residents' change. Updated plans or the plans for new residents are displayed on the wall for two weeks to enable staff to familiarise themselves with the content, before being placed in a folder. A master list of all residents' food preferences (including dislikes) and dietary needs is displayed in the kitchen. This includes residents who have special dietary needs including altered textures. Nutritional supplements are recorded on the medicine records and signed when given. Residents were observed being assisted by staff with their meals and beverages as required in an unhurried and respectful manner.
Standard 1.3.6: Service	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised

Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and that communication and care provided is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and clinical resources was available for service provision. Nineteen residents have an air mattress on their bed. Sixteen residents have air cushions in use. A physiotherapist is on site weekly and is involved with developing rehabilitation plans for applicable residents.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is normally overseen by the diversional therapist (DT), however the DT was on leave at the time of audit. A heath care assistant was facilitating the programme during this time weekdays from 9.30 am – 4.00 pm. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents individually and as a group. The resident's activity needs are evaluated monthly and as part of the formal six-monthly, and annual care and care plan review. Records of participation / attendance are maintained daily. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families / whānau are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find the programme interactive. Participation is voluntary. Activities include exercises, board games / puzzles, outside activities, outings, pet visitation, and music. Happy hour occurs weekly on Friday. Special days are celebrated, along with residents' birthdays. Church services are held on site. The activities programme is displayed in several areas around the facility. Staff assist residents in attending (where necessary). All residents and family members interviewed were satisfied with the activities available. One resident stated he chose not to attend activities, however kept busy doing other activities of choice in the resident's room.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If health care assistants note any changes in a resident's condition, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, exacerbation of asthma, episodes of pain, pressure injuries, weight loss, skin tears, bruising and wounds. Neurological assessments are undertaken for at least 12 hours for residents following unwitnessed falls or where an injury to the head may have occurred. Bowel charts, food charts, and fluid

		balance charts are maintained where indicated. When necessary, and for unresolved problems, long term care plans are added to or updated. Residents and families / whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness expires 04 June 2018. The building warrant of fitness sighted is displayed in the entrance to the facility.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro-enteritis and other infections. The infection prevention and control (IPC) coordinator who is the clinical manager reviews all reported infections. The registered nurse on duty is responsible for documenting the infections as they occur. New infections and any required management plans are discussed at shift handover, to ensure early and appropriate interventions occurs. Short-term care plans are developed and evaluated regularly until the infection has resolved. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. The graph of infections reported in 2018 to date is displayed in the staff tea room. Trends are identified from the past year and this is reported by the clinical manager to the staff and managers. A comparison review of the 2017 infection rate to that reported in 2016 has also occurred. An outbreak of gastroenteritis occurred in July 2017 and involved 20 residents and three staff. All residents made a full recovery. A detailed outbreak investigation has occurred. The majority (15) of the residents had symptoms on the second day of the outbreak. The interventions were successful in bringing the outbreak under control in a timely manner.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator a registered nurse provides support and oversight for enabler and restraint management in the facility. The coordinator was not available for the audit. The clinical manager demonstrated a sound knowledge of the organisation`s policies and

is actively minimised.		procedures and was responsible for overseeing the processes implemented. On the day of the audit no enablers were in use and eight restraints were in use. The process ensures the ongoing safety and wellbeing of residents using a restraint. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and records reviewed of those residents who have approved restraints. The staff interviewed understood that an enabler is the least restrictive and used voluntarily at the resident's request.

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.