

Lyndale Care Limited - Lyndale Villa and Manor

Introduction

This report records the results of a Partial Provisional Audit; 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: Lyndale Care Limited

Premises audited: Lyndale Villa||Lyndale Manor

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 5 July 2018 End date: 5 July 2018

Proposed changes to current services (if any): A disused area in Lyndale Manor has been renovated internally to create three new bedrooms, a wet area shower and toilet and a stand-alone toilet. HealthCERT gave permission while the auditors were on site to include the renovation as a partial provisional audit in this audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 48

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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
Yellow	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
Red	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

Lyndale Villa and Lyndale Manor are certified to provide residential care for up to 56 residents who require rest home and dementia level care Lyndale Villa can accommodate 36 residents including eight rented supported living units that are also certified. Lyndale Manor provides accommodation for 20 residents who require dementia level care. On the day of the audit there were 28 beds occupied in Lyndale Villa and 20 dementia level residents residing in Lyndale Manor. The facility is operated by Lyndale Care Limited.

This surveillance audit was conducted against aspects of 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 files, observations and interviews with residents, families, management, staff and a nurse practitioner. A partial provisional audit was also undertaken to establish the level of preparedness of the provider to operate three new bedrooms, a bathroom and a stand-alone toilet at Lyndale Manor.

The areas requiring improvement from the previous certification audit relating to meeting timeframes for care plans and interRAI assessments, aspects of medicine management and the designation of staff writing in progress notes not being clear have been addressed. The requirement relating to the names of staff not being clear remains open.

There are improvements required from this audit relating to registered nurses recording entries in progress notes, orientation and training for the recreation officer at Lyndale Manor, a lack of planned activities, no activities assessments and care plans developed for the dementia level residents, current restraint competency assessments for clinical staff, the management of controlled drugs

including incident reporting, maintenance of the medicine fridge and freezer, no cleaning schedule in the kitchen and no pest control plan. Prior to occupying the renovated area in Lyndale Manor, a copy of a certificate of public use and evidence from the New Zealand Fire Service stating the current fire evacuation scheme remains approved and operative is required.

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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Open communication between staff, residents and families is promoted and confirmed by resident and families to be effective. There is access to formal interpreter services from the local district health board (DHB) if required.

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner. An investigation has been undertaken by the DHB since the previous certification audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Lyndale Care Limited is the governing body and is responsible for the service provided. A business strategic plan and quality, risk and management systems are fully implemented at Lyndale Villa and Lyndale Manor. Systems are in place for monitoring the service, including regular meetings between the general manager and the owner.

The facility is managed by a general manager who has been in the position for 24 years and who is leaving in August 2018. A new manager who is an experienced registered nurse has been appointed to the position. The new manager has owned an aged care facility and is currently managing an aged care facility. An experienced registered nurse has recently been appointed to the position of clinical nurse manager and is responsible for the clinical service.

There is an internal audit programme. Adverse events are documented on incident/accident forms. Incident/accident forms and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address any areas that require improvement. Quality, health and safety, clinical, staff and residents' meetings are held on a regular basis. The hazard register evidenced review and updating of risks and the addition of new risks.

Human resources processes are in place. An in-service education programme is provided, and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on acuity levels of residents and skill mix of staff. Registered nurses are rostered on duty on the morning shifts in both facilities. The registered nurses are rostered on call after hours.

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 medium or high risk and/or unattained and of low risk.
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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme in both facilities is overseen by two recreation officers and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines in both facilities are managed and consistently implemented using an electronic system. Medications are administered by registered nurses and team leaders (senior care staff), all of whom have been assessed as competent to do so.

The food service in both facilities meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. Both kitchens were well organised and had food control plans registered with the local council. Residents and their families verified overall satisfaction with meals.

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.		Some standards applicable to this service partially attained and of low risk.
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Both Lyndale Villa and Lyndale Manor have a current building warrant of fitness displayed. Lyndale Manor is spacious with lots of room for residents to mobilise. All rooms are single and of a good size and the majority have ensuite bathrooms. A preventative and reactive maintenance programme is in place. Dining and lounge areas are spacious. External areas have seating and shade. Essential emergency and security systems are in place with regular fire evacuation drills. An unused area in Lyndale Manor has been renovated internally to provide three new bedrooms, a bathroom and toilet and another stand-alone toilet.

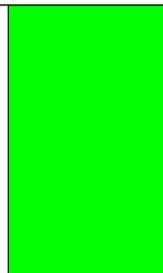
Restraint minimisation and safe practice

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 service has policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using a restraint or an enabler at the time of audit.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education. Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	19	0	5	2	0	0
Criteria	0	53	0	4	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and there is complaints information and forms available at the foyer of both facilities. All complaints have been entered into the complaints register. Two complaints were reviewed and actions taken, through to an agreed resolution, were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The general manager is responsible for complaint management and follow up. Staff interviewed confirmed an understanding of the complaint process and what actions are required.</p> <p>The general manager reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, Accident Compensation Corporation (ACC), Coroner or Police since the previous certification audit. There has been an investigation and review by the DHB since the last certification audit relating to a complaint concerning the care of a resident. Documentation was reviewed relating to the review, including corrective actions developed and implemented by the provider as a result of recommendations made. The resident has been reassessed and is no longer residing at Lyndale Villa.</p>
Standard 1.1.9:	FA	Residents and families stated they are kept well informed about any changes to their own or their relative's status

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>and were advised in a timely manner about any incidents or accidents. Families stated they are now advised before the GP visits their relative of the three-monthly review. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the local DHB if required. Training sessions on effective communication have been provided to staff.</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>The business strategic plan is reviewed annually and includes the purpose, values, scope, direction and goals and objectives of the organisation. An organisational flowchart shows the positions within the organisation. The owner visits weekly and the general manager reported discussions and reporting includes staffing, bed status, health and safety, significant incidents, risk management, complaints and maintenance. The GM reported a governance meeting is held quarterly between the owner, the GM and the clinical nurse manager (CNM).</p> <p>The general manager (GM) reported they have resigned from the position and leave in August after orientating the new manager/RN who starts on the 6 August 2018. The GM has been in the role for 24 years. The new manager is an experienced RN, especially relating to the aged care sector, has owned and managed an aged care facility and is currently managing a large facility in the region. A clinical nurse manager (CNM) has been appointed and they have been in the position for approximately three months. The CNM has prior experience in the aged care sector both as a RN on the floor and as a clinical manager. The CNM is based at Lyndale Manor and is responsible for oversight of the clinical governance for both facilities. The CNM currently meets with the RNs at Lyndale Villa once a week to discuss any concerns and chairs the clinical meetings. Lyndale Manor is situated in the same street as Lyndale Villa, approximately 250 metres separate the two facilities. The RNs who work at Lyndale Villa reported the CNM is only a phone call away if they require input or advice from the CNM.</p> <p>Lyndale Villa is certified to provide 36 rest home level beds and 28 beds were occupied, including one resident under 65 years of age, one boarder and eight independent supported studios that people rent. Lyndale Manor is certified to provide 20 dementia level beds and all beds were occupied. Once the renovation has been certified, the total beds available at Lyndale Manor will be 23.</p> <p>Lyndale Care Limited has contracts with the DHB for aged related residential care services and day and respite care.</p> <p>The general manager advised that HealthCERT and the DHB have been notified by the owner of the appointment of a CNM since the previous certification audit and that they are aware of the requirement to notify HealthCERT and the DHB of the change of manager.</p>

<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>	<p>FA</p>	<p>When the general manager is absent temporarily, the two administrators fill the position with support from the owner. When the CNM is absent a senior RN takes responsibility for clinical governance.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The quality and risk management plan reviewed, is used to guide the quality programme and includes a mission statement, philosophy, goals and objectives.</p> <p>The resident and relative satisfaction survey for Lyndale Villa and the relative satisfaction survey for Lyndale Manor 2017 were reviewed and results indicated that residents and families were satisfied with the services provided.</p> <p>Completed audits for 2017 and 2018, clinical indicators and quality improvement data was recorded on various registers and forms and were reviewed. Quality improvement data provided evidence the data was being collected, collated and analysed to identify trends and corrective actions developed and evaluated.</p> <p>Staff meetings are held monthly and minutes were reviewed. The meetings include health and safety, quality, infection control and restraint. There was documented evidence of reporting on various clinical indicators, any trends identified and quality and risk issues in these meetings. Staff reported that copies of meeting minutes are available for them to review in the staff areas and they discuss trend and any corrective actions. Clinical meetings are held weekly where the registered nurses review residents who have changes in their health status that are of concern. Minutes of meetings reviewed were comprehensive.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. A clinical consultant has reviewed policies and procedures and updated those identified as having gaps. They are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for the service delivery. (Refer also criterion 1.2.9.9)</p> <p>Risks are identified. There is a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual, occupancy, financial, environmental and</p>

		clinical risk.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Adverse, unplanned or untoward events are documented by staff on incident/accident forms, apart from two controlled drug errors (see criterion 1.3.12.1) and are reviewed by the CNM. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Adverse event data is collected, collated and analysed. The CNM completes a monthly accident/incident report and a plan of the facilities showing where and what time of the day the incident/ accident occurred. The data is reported back to staff. Staff confirmed this.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or changes in the resident's health status. Families confirmed they are advised in a timely manner following adverse events or changes in their relative's condition.</p> <p>Staff are aware of essential notification responsibilities. The general manager stated there has been one Section 31 notified for a Stage 3 pressure injury made to HealthCERT since the last certification audit. The GM stated there was a delay in the notification being submitted. This relates to the investigation and review by the DHB under 1.1.13. The general manager reported there have been no other notifications made to external agencies.</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>	PA Low	<p>Staff files reviewed included job descriptions which outline accountabilities, responsibilities and authority, employment agreements, references, competency assessments, education records and police vetting. Staff files also evidenced completed orientations apart from the recreation officer for Lyndale Manor. Electronic registers record competencies, first aid, annual practising certificates, and on-going education.</p> <p>The orientation process, including competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided. Staff confirmed they have completed an orientation, apart from the recreation officer, including competency assessments and that this prepared them well for their role.</p> <p>The education programme is the responsibility of one of the administrators. Documentation evidenced in-service education is provided at least monthly and during the monthly staff meetings and at handover. Individual certificates of training, attendance and competencies for medication were evidenced on staff files. Restraint competencies have not been returned from clinical staff. Three of the four RNs are interRAI trained and have current competencies. There is at least one staff member on duty with a current first aid certificate at both facilities. Staff have been provided with extra training including wound management and effective communication.</p> <p>The administrator reported they are currently changing to a new system that is a New Zealand Qualification Authority education programme for staff. This consists of three hourly sessions and is repeated to capture all staff. The programme covers all required subjects. All staff working at Lyndale Manor have completed the dementia specific modules. Staff files confirmed this. The GM reported four caregivers are currently completing the University</p>

		<p>of Tasmania certificate in the management of dementia.</p> <p>The recreation officer who works at Lyndale Manor has completed training in caring for people with dementia. However, they have not completed any training relating to providing activities to residents with dementia.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice. Staff confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</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>	FA	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. Staffing levels are adjusted to meet the changing needs of residents, resident acuity including interRAI, occupancy and the environment. Rostering is based on the handbook indicators for safe aged care and dementia care. Staff are also consulted about any changes in workloads. The GM and CNM work full time Monday to Friday. Registered nurse cover is provided in both facilities 7am to 3.30pm, with two RNs on duty in Lyndale Manor. The RNs are rostered on call after hours. There are three experienced RNs and one new graduate employed. The roster showed at least one staff member per shift has a current first aid certificate. There are dedicated cleaning and laundry staff. Two recreation officers are employed, one in each of the facilities from 10 am to 12 midday and 1 pm to 5 pm Monday to Friday. (Refer also to criterion 1.2.7.5). Care staff in the dementia unit are also responsible for providing some activities, especially during the weekend.</p> <p>The GM reported that when the three extra beds in Lyndale Manor are occupied, caregiver hours will be increased. One caregiver will start work at 6 am (rather than 7 am) and the short afternoon shift caregiver hours will be extended from four hours to six hours.</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and family members reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when</p>	PA Low	<p>Residents' files were maintained securely. No information was publicly accessible or observable. Archived files were stored securely but were easily retrievable.</p> <p>Clinical records reviewed were integrated, including information such as medical notes, assessment information and reports from other health professionals.</p> <p>Clinical staff write in the progress notes every shift and the designation of the staff member making the entry is clear. However, the name of the staff member making the entry is not always legible. Entries are only made by RNs if a resident's condition changes. There is no policy on the timeframes or reasons when RNs are expected to make entries into the progress notes.</p>

required.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>There was consistent evidence of three monthly medication reviews by the GP or NP. Eyedrops in use had the date of first use recorded and medications stored in the food fridge in Lyndale Manor were in a separate container. This addresses previous requirements for corrective action. The medicine fridge at Lyndale Villa was specifically for medications. The records of temperatures for the medicine fridges in both areas were within the recommended range. However, the medication fridge in the Villa was extremely iced up.</p> <p>A safe electronic system for medicine management was observed in both areas 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. A staff member observed administering medicines is observed as competent to perform the function they manage.</p> <p>Interview with the clinical nurse manager (CNM) and RN verified the medication system in place at Lyndale Manor will not be impacted on by the addition of three additional beds.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in both areas in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>A review of the controlled drug register in Lyndale Villa identified compliance in controlled drug management. However, a discrepancy in controlled drug management was identified at Lyndale Manor.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and required to be recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified with regards to the one medication error that had been reported. Only one medication error has been reported this year and no incident forms are sighted for two identified administration errors concerning controlled drugs.</p>

		Standing orders are not used.
<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>	PA Low	<p>The food service is provided on site in each facility by two cooks 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 within the last two years. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place for each facility and has been registered with the Masterton District Council, this is due to expire 31 July 2019. No evidence of a verification audit was sighted.</p> <p>Food temperatures, including for high risk items, in both facilities are monitored appropriately and recorded as part of the plan. The cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A cleaning record is sighted; however, there is no cleaning schedule. A range of food is stored in an outside shed at Lyndale Villa. The shed is accessible to rodents as evidenced by gaps in the floor and several mouse traps being used.</p> <p>A nutritional assessment is undertaken for each resident on admission to each 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. Special equipment, to meet residents' nutritional needs, is available.</p> <p>Residents in the secure unit have access to food always. The planned addition of three extra residents at Lyndale Manor, will not have an impact on the management of food services at the Manor, as confirmed by the cook and general manager.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and the sporadic resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents in both facilities were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	FA	<p>Documentation, observations and interviews at both the Manor and the Villa verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a range of resident's individualised needs was evident in all areas of service provision. The NP interviewed, verified that any recent requirement for medical input is sought in a timely manner and that medical orders are followed. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the types of care provided and in accordance with the residents' needs.</p>

assessed needs and desired outcomes.		
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Moderate</p>	<p>The activities programme in each of the two facilities is provided by two recreation officers, neither of whom have formal training. The recreation officer in the secure unit has completed formal training in caring for residents with dementia; however, has no formal training or experience specifically around providing activities to these residents (refer criterion 1.2.7.5), nor has any mentoring support or guidance in the type of programme to be implemented to meet the residents' needs been provided. Training in diversional therapy is to be commenced soon.</p> <p>Prior to the recent resignation of a trained diversional therapist (DT) two months ago, the DT completed a social assessment and history on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments and evaluations were regularly reviewed to help formulate an activity programme that was meaningful to the residents and the resident's activity needs were evaluated regularly. This has not occurred over the past two months.</p> <p>The planned monthly activities programme presently offered matches the skills, likes, dislikes and interests that have been identified when interviewing residents and their families and observations of residents' involvement in the activities provided. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered including involvement in the local inter rest home games and golden oldies outings.</p> <p>Residents in the secure unit have a twenty-four-hour lifestyle care plan, that includes residents' activities and interests. This has been completed by the RN.</p> <p>The activities programme is discussed at the minuted residents' and family meetings and indicated residents' and family input is sought and responded to. However, minutes of residents' meetings show that meetings have been sporadic, and not three monthly as policy identifies. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents and families interviewed in both areas confirmed they find the programmes meet their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN as verified in documentation and interviews.</p> <p>Except for those evaluations referred to in criterion 1.3.7.1, formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain and weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans sighted (eg, a skin tear management plan) was evaluated each time the dressing was</p>

		changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<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>Safe and appropriate environment-waste management procedures including hazardous substances are in place and incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation, including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets were available at Lyndale Manor and are accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There was provision and availability of protective clothing and equipment in the laundry appropriate to the recognised risks. A sluice is situated in the dirty side of the laundry.</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>	PA Low	<p>Lyndale Manor provides wide passageways with an internal walking circuit, good size bedrooms and large communal areas for residents to frequent. An old disused area consisting of three bedrooms in Lyndale Manor has been renovated into three bedrooms, a wet area bathroom including a toilet, a stand-alone toilet and a storage cupboard. This will increase the total number of beds available from 20 to 23. The GM reported the increase of three beds will have no impact on the physical environment. Although the latest renovation has been completed, the local authority has not yet issued a certificate of public use.</p> <p>Current building warrants of fitness are displayed at both facilities. There have been no structural alterations at Lyndale Villa since the last certification audit.</p> <p>Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. The testing and tagging of equipment and calibration of bio medical equipment was current.</p> <p>A proactive and reactive maintenance programme is in place that ensures buildings, plant and equipment are maintained to an adequate standard. A maintenance person works full time across both facilities.</p> <p>The external areas are secure and safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas including lots of places to sit and shaded areas. Residents are protected from risks associated with being outside.</p>

		<p>Staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use it.</p> <p>Families confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned.</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 or receiving assistance with personal hygiene requirements.</p>	FA	<p>The majority of bedrooms in Lyndale Manor have full ensuites. There are an adequate number of accessible communal showers, toilets and hand basins for residents. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. The renovated area has a new bathroom including a toilet and a stand-alone toilet.</p> <p>Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote residents' independence. Doors have privacy locks with safety releases and vacant/engaged signage.</p>
<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	<p>All bedrooms provide single accommodation. All rooms were personalised to varying degrees. Bedrooms, including the three new bedrooms, are large enough to provide personal space for residents and allow staff and equipment to move around safely.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>The lounges and dining areas are large in Lyndale Manor. Access to all communal areas is appropriate. Residents were observed moving freely within these areas. Families confirmed there are alternate areas available to them if communal activities are being run in one of these areas and their relative does not want to participate in them.</p>

<p>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>		
<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>	<p>FA</p>	<p>Cleaning and laundry policies and procedures are available. There are policies and procedures for the safe storage and use of chemicals/poisons.</p> <p>All linen is washed on site and there is a dirty to clean flow provided. Laundry/cleaning staff are responsible for the management of laundry and cleaning of the facility. Staff described the management of laundry and cleaning and processes followed.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed.</p> <p>Observations provided evidence that safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals were labelled and stored safely within these areas; chemical safety data sheets or equivalent were available; and appropriate facilities exist for the disposal of soiled water/waste. Convenient hand washing facilities are available, and hygiene standards are maintained in storage areas.</p> <p>Families stated they were satisfied with the cleaning and laundry services. The family satisfaction survey confirmed this.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and</p>	<p>PA Low</p>	<p>Documented systems were in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification. Policy/procedures include the safe and appropriate management of unwanted and/or restricted visitors. External sensor lights are positioned around Lyndale Manor. External doors are secure and a swipe card is required for entry.</p> <p>A New Zealand Fire Service letter evidenced approval of the fire evacuation scheme for Lyndale Manor. Trial evacuations are undertaken six-monthly. The GM reported the New Zealand Fire Service had been involved in the renovation and advised they did not think a new fire evacuation scheme that includes the renovation needed to be</p>

<p>security situations.</p>		<p>submitted.</p> <p>Information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is emergency lighting supplied by a generator, torches, gas for cooking, extra food supplies, emergency water supply blankets and cell phones.</p> <p>A call bell system is in place including the three new bedrooms, bathroom and stand-alone toilet. Call bells are accessible/within reach and are available in all resident areas. Families confirmed their relative can access the call bells and staff respond in a timely manner.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Procedures are in place to ensure the service is responsive to family feedback in relation to heating and ventilation, wherever practicable. Families and residents confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The renovated area is heated with panel heaters.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>FA</p>	<p>The infection prevention and control programme, led by an experienced infection control nurse, aims to prevent and manage infections. The present programme will not be impacted on by the addition of three additional beds in Lyndale Manor. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.</p> <p>Signage at the entrance to both facilities requests anyone who is or has been unwell in the past 48 hours not to enter the facility. Staff are familiar with how long they are to stay away from work if they are unwell.</p> <p>Staff demonstrated good principles and practice around infection control.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at each facility's handover, to ensure early intervention occurs.</p> <p>The infection control nurse and CNM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy has a section on enablers that includes a definition, assessment and evaluation. The restraint coordinator, who is a RN, reported the aim is not to use any form of restraint. There were no residents using a restraint or an enabler at the time of audit. Staff interviewed demonstrated knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint. Not all clinical staff have current restraint competency assessments. (See criterion 1.2.7.5).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>The inservice calendar for 2018 was reviewed. The programme is the responsibility of the administrator. Documentation evidenced in-service education is provided at least monthly and during the monthly staff meetings and at handover. External educators are sourced, and RNs can attend sessions at the local DHB and are expected to share information with the rest of the staff. Individual certificates of training, attendance and competencies for medication were evidenced on staff files. The administrator reported competency questionnaires for restraint have been handed out to clinical staff, however few have been returned to date. Three of the four RNs are interRAI trained and have current competencies. Current first aid certificates were sighted on staff files and there is at least one staff member with a current first aid certificate on each shift in both facilities.</p> <p>As a result of the investigation/review by the DHB, registered nurses have received training around the application of the Waitemata DHB ‘RN Care Guides for Residential Aged Care’, plus a workshop on communication processes. The ‘Professional Development and Recognition Programme’ (PDRP) process is also being implemented</p>	<p>(i) Not all clinical staff have current restraint competency assessments. (ii) the recreation officer at Lyndale Manor has no experience, training or a qualification specific to providing activities for residents who have dementia and has not completed an orientation to the position.</p>	<p>Provide evidence that (i) all clinical staff have a current restraint competency assessment (ii) the recreation officer at Lyndale Manor is provided with training or a qualification specific to providing activities for residents who have dementia and (iii) an orientation to the position is completed.</p> <p>60 days</p>

		<p>with the DHB for new RNs. Care staff have received training on the Waitemata DHB 'Care Givers Guide for Residential Aged Care'. The clinical consultant has also been undertaking coaching along-side the RNs and the RNs reported this has helped with their practice.</p> <p>All staff working at Lyndale Manor have completed the specific dementia modules. Four caregivers are currently completing the University of Tasmania certificate in the management of dementia. The recreation officer who works at Lyndale Manor has completed training in caring for people with dementia. However, they have not completed any training relating to providing activities to residents with dementia and although they have an orientation on file for when they started work as a caregiver, there is no evidence of an orientation/induction to the position of recreation officer. The recreation officer confirmed this.</p>		
<p>Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.</p>	<p>PA Moderate</p>	<p>Caregivers make entries into residents' progress notes each shift and the designation of the staff member is clear. The name of the staff member making the entry is not always legible. This was a finding at the last certification audit. Entries by the RNs in the progress notes are only made if the health status of a resident changes. Registered nurses confirmed this. There is no policy on the timeframes or reasons for when RNs are expected to make entries into the progress notes.</p> <p>Clinical records reviewed were well organised and integrated, including information such as medical notes, assessment information and reports from other health professionals.</p>	<p>(i)The names of the staff members making entries into the residents' progress notes is not always legible. (ii) There is no policy that guides RNs as to timeframes and reasons for making entries into residents' progress notes.</p>	<p>Provide evidence that: (i) the names of all staff members who write in the residents' progress notes are legible; (ii) a policy relating to timeframes and the reasons for RNs to make entries into the residents' progress notes is developed and implemented.</p> <p>90 days</p>
<p>Criterion 1.3.12.1 A medicines management system is</p>	<p>PA Moderate</p>	<p>A safe electronic system for medicine management was observed in both areas 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. The</p>	<p>The management of controlled drugs at Lyndale Manor, is not consistent with</p>	<p>Provide evidence that the management of controlled drugs in Lyndale Manor is in</p>

<p>implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>staff members observed / interviewed in regards administering medications are competent deemed competent to perform the function they manage.</p> <p>A review of the controlled drug register in Lyndale Manor identified one recent event whereby the two staff who checked the medication out at 7am, differed from the two staff (one a RN) that recorded electronically, administering the medication an hour later. This event was verified by interview with the CNM to have occurred and was related to a perceived time pressure.</p> <p>A review of the electronic administration records for controlled drugs identified, where a second signature was required to verify accuracy, in two administration events, the same person signed twice. This was verified by interview to be occurring, as a staff member trained as a second checker was not rostered on those days. There were no incident forms to record these events had occurred.</p> <p>The freezer box in the medication fridge at Lyndale Villa was iced up, with no evidence available to verify when it was last defrosted.</p>	<p>the safe medication management systems in place at Lyndale Care Ltd. Incident forms are not filled out every time there is an error.</p> <p>The medication fridge at the Villa requires defrosting.</p>	<p>line with best practice guidelines.</p> <p>Provide evidence staff in Lyndale Manor are aware incident forms are required for medication errors.</p> <p>Provide evidence the medicine fridge is defrosted regularly.</p> <p>30 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>Both facilities have a food control plans registered with the council, though no evidence was sighted the plan has been verified by a verification audit. Both facilities have well-appointed kitchens, with a cleaning record filled in each day; however, there was no evidence of a cleaning schedule in both kitchens. The outside freezer at Lyndale Villa is very iced up. The cook was unable to verify when this was last defrosted and how often this occurs. A range of food is stored at the Villa in an outside metal shed. There are gaps in the floor, the door is wide open and needing maintenance, and several mouse traps are visible. There was no pest management plan sighted to manage the risk of rodents.</p>	<p>A food control plan is in place for both facilities, however there is no evidence of a cleaning schedule, a schedule to ensure the freezer at the Villa is defrosted in a timely manner nor is there evidence of a pest control plan to manage pests in the food storage shed at the Villa.</p>	<p>Provide evidence the freezers have been defrosted, and a cleaning schedule and a pest control plan are in place.</p> <p>180 days</p>

<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Moderate</p>	<p>The activities programme in each of the two facilities is provided by two recreation officers. There is no oversight of the programme by a qualified person to verify it meets the needs of residents with dementia.</p> <p>New residents who have been admitted recently to both the Manor and the Villa have no social/activities assessments in their files that identify what the residents' skills, interests, strengths or past interests have been. There are no documented activities plan in these residents' file that document the residents' goals and what the plan is to achieve these goals. Residents who have resided for over two months have no evidence of recent up to date evaluations of the activities plans. Interviews with both recreation officers, confirmed they were unaware of the requirement for documentation of an activities assessment, activities plan and ongoing evaluation to gauge the effectiveness of the programme being offered.</p>	<p>There is no documented assessment of residents who have been recently admitted to determine the residents skills / interests or strengths. In the past two months there has been no evaluation to determine the activities programme meets the residents needs.</p> <p>There is no process in place to verify the activities provided in both facilities will develop and maintain residents' strengths, skills and interests.</p>	<p>Provide evidence the activities programme provided in the secure unit is delivered or overseen by an appropriately qualified person.</p> <p>Provide evidence that the activities delivered are planned and facilitated to develop residents' skills, strengths and interests.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>Current building warrants of fitness are displayed at both facilities that expire on the 30 June 2019. Documentation evidenced the testing and tagging of equipment and calibration of bio medical equipment was current. Hot water temperatures are within the recommended range including the renovated area. The internal renovation of a disused area consisting of three bedrooms into three bedrooms, a wet area bathroom and toilet, a stand-alone toilet and a storage cupboard has been completed. The GM reported the local council has not yet</p>	<p>A certificate of public use has not yet been issued by the local authority for the renovation completed at Lyndale Manor.</p>	<p>Provide a copy of the certificate for public use for the completed renovation.</p> <p>Prior to occupancy days</p>

		issued a certificate of public use for the renovation.		
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	<p>A New Zealand Fire Service letter evidenced approval of the fire evacuation scheme for Lyndale Manor dated 23 March 2012. Trial evacuations are undertaken six-monthly. The GM advised they did not think a new fire evacuation scheme that includes the renovation needed to be submitted to the New Zealand Fire Service. However, there was no documentation available from the NZ Fire Service to evidence that the fire evacuation scheme remains approved and operative as a result of the renovation.</p>	<p>Evidence was not available from the NZ Fire Service to show that the fire evacuation scheme for Lyndale Manor remains approved and operative following the completion of the renovation.</p>	<p>Provide evidence from the NZ Fire Service that the fire evacuation scheme remains approved and operative.</p> <p>Prior to occupancy days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.