# Parkwood Trust Incorporated

## Introduction

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

The audit has been conducted by 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Parkwood Trust Incorporated

**Premises audited:** Parkwood Retirement Village

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 29 August 2018 End date: 30 August 2018

**Proposed changes to current services (if any):** Addition of Hospital - medical services. This audit confirms the provider is able to meet all the requirements for this service.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 78

# 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 |
|  | 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

Parkwood Retirement Village provides rest home and hospital level care for up to 86 residents. The service is operated by Parkwood Trust Incorporated, a charitable trust set up in the early 1970’s and managed by a general manager and a nurse manager. Residents and families spoke positively about the care provided.

This certification 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 files, observations and interviews with residents, family members, management, staff, a resident advocate and a general practitioner.

This audit has resulted in three continuous improvement ratings relating to best practice, the activities programme and medicine management.

## Consumer rights

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| --- | --- | --- |
| 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. |

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

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

The Parkwood Retirement Trust business and quality and risk management plans include the scope, goals, critical success factors and strategies, and the mission statement of the organisation. Monitoring of the services provided to the governing body (a voluntary trust) is regular and effective. An experienced and suitably qualified person, who has been with the Trust for a number of years, manages the facility supported operationally by a nurse manager.

The quality and risk management system includes collection and analysis of quality improvement data, identifies 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 risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained on site using electronic and hard copy files.

## Continuum of service delivery

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| --- | --- | --- |
| 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 organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

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. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is run by three diversional therapists 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 are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses, enrolled nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified a high level of satisfaction with meals.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The purpose-built facility is spacious, clean, well maintained and meets the needs of residents. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. The large number of external areas around the facility are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

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| 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. Three restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Any use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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| 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, microbiologist, and an external advisory body. 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, data is analysed and trended. Results are 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 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 3 | 98 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Parkwood Retirement Village (Parkwood Lodge) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. Input from the Health and Disability Advocacy Service is included at staff training sessions. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using Parkwood Lodge’s standard consent forms including for photographs, outings, invasive procedures and collection of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s file. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents were given a ‘welcome folder’ that contained a range of information on Parkwood Retirement Village. The folder includes a copy of the Code, and information on the Advocacy Service. Brochures related to the Advocacy Service were displayed in the facility, with additional brochures available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Parkwood Lodge has a residents’ advocate, who is a resident of the facility and runs the residents’ meetings. Interviews with the advocate verified residents have minimal concerns. Any concerns are promptly responded to by management. The advocate was familiar with the advocacy service and how to contact them if any residents required advice or assistance.  Staff were aware of who the residents advocate was and how to access the Advocacy Service. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents of Parkwood Lodge are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaint forms are also available at reception and in a number of areas around the facility.  The complaints register reviewed showed that 11 complaints have been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The quality managers are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents (eight) and family members (five) interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the ‘welcome folder’ in the admission information provided, and discussion with staff at any time. The Code is displayed on the wall and in common areas together with information on advocacy service, Parkwood Trust’s mission statement and philosophy, resident meeting minutes, the newsletter, how to make a complaint, how to make a compliment and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families of Parkwood Lodge confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room. There are many small lounge areas throughout the facility where residents can access quiet areas.  Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There were no residents in Parkwood Lodge at the time of audit who identified as Māori, however interviews and documentation verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident’s personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met, and this supported that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The management of Parkwood Lodge encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, community dieticians, services for older people, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests and is quoted as saying “an excellent level of care is provided by staff of Parkwood Retirement Village. They are great advocates for their residents”.  Staff reported they receive management support for external education and access their own professional networks, such as on-line forums, to support contemporary good practice.  An ongoing initiative to provide and maintain the best quality of life and end of life care for residents at their families is an area that has been recognised in a previous certification audit and continues to be recognised as one of continuous improvement.   Other examples of good practice observed during the audit included a commitment by management to providing an environment in which staff are happy, as evidenced by low staff turnover and the number of highly experienced long-term staff.  A continued commitment to improving the quality of care provided is evidenced by an ongoing initiative aimed at a reduction in the number of falls, a commitment to reducing the number of infections and subsequent use of antibiotics, and a commitment to improve training opportunities for staff. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members of residents stated they were kept well informed about any changes to their own or their relative’s status, 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. 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.  Interpreter services can be accessed via Interpreting New Zealand when required. Staff knew how to access this service although reported interpreter services were rarely required. |
| 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 strategic and business plans, which are reviewed annually, outline the scope, goals, critical success factors and strategies along with the mission statement of the organisation. The documents described both annual and longer term goals and the associated steps to achieve these goals operationally, in conjunction with the quality plan. A sample of monthly reports to the board of trustees (all voluntary members including four residents from across the whole retirement complex) showed adequate information to monitor performance is reported including financial performance, emerging risks and issues and progress towards achieving of the organisational goals.  The service is managed by a general manager (GM) who holds relevant qualifications and has been in the role for many years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. He is supported by a nurse manager who also has significant experience in the aged care sector. They confirmed knowledge of the sector, regulatory and reporting requirements. The GM maintains currency through regular attendance at sector meetings, conferences and maintaining close links with the national body and other local organisations.  The service holds contracts with the DHB for both hospital and rest home level care. Seventy eight residents were receiving services under the contract (30 hospital level and 48 rest home level) at the time of audit. |
| Standard 1.2.2: Service Management  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. | FA | The GM is supported by a nurse manager with 17 years’ experience in the sector who, when the GM is absent, carries out all the required duties under delegated authority. During absences of key clinical staff, clinical management is overseen by senior registered nurses (RN’s) who are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. |
| 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 | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents, complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections and any medication errors. The quality programme is managed by the two quality managers, one taking responsibility for operational quality programmes and the other with responsibility in administration activities. The quality team has representation from across the organisation.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the team leaders, clinical and quality and risk team regular meetings. Staff reported their involvement in quality and risk management activities through audit activities as well as always being able to make suggestions and discuss ideas with management on an ongoing basis. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually along with regular monthly meetings between the GM and the residents. Also, following admission, all residents have a six weekly follow up to ensure there are no concerns. One recent issue identified at the residents’ meeting was a heating problem in one of the public areas. This was immediately referred to the maintenance team and resolved quickly.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The quality managers described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The managers are familiar with the Health and Safety at Work Act (2015) and have 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 incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed, reported to the quality team and integrated into the quality reporting process.  The quality manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the MoH or other regulatory authorities 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 | Human resources management policies and processes are based on good employment practice and relevant legislation. 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 maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a six month period.  Continuing education is planned on an annual basis, including mandatory training requirements. Internal training is carefully monitored to ensure all staff complete the required sessions. External speakers come into the facility to complete training where relevant. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. A staff member is the internal assessor for the programme. Staff reported they are encouraged and supported to undertake external training opportunities if appropriate. There are sufficient trained and competent registered nurses (eight) who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. |
| 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 documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a fortnightly roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the clinical manager (CM). They are also provided with written information about the service and the admission process.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Capital & Coast District Health Board’s (CCDHB) ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred from a local acute care facility showed transfer was managed in a planned and co-ordinated manner. The resident reported being kept well informed during the transfer. |
| 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 at Parkwood Lodge was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic 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 medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  Controlled drugs are stored securely 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. Improved management of controlled drugs occurred with the implementation of an electronic medication management system.  The records of temperatures for the medicine fridge and the medication room 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 all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.  There were eleven residents (four in the hospital and seven in the rest home) who were self-administering medications at the time of audit. Two (rest home residents) of the eleven, fully self-administer while the other nine, administer under supervision. Appropriate processes are in place to ensure this is managed in a safe manner.  Medication errors are reported to the RN and CM and 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.  Standing orders are used and in line with standing orders guidelines. |
| 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 at Parkwood Lodge is provided on site by a cook 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 August 2017. Recommendations made at that time have been implemented. A food control plan has been registered with the Ministry of Primary Industries (MPI) 27 June 2018.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  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. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. An exercise book in the dining room records residents’ comments around the food service. Comments are complimentary with any areas of dissatisfaction promptly responded to. The cook at Parkwood Lodge is aware of some residents ongoing dissatisfaction with food, and meets with the residents on admission, at residents’ meetings and one on one on an ongoing basis, to meet all residents’ requests. Each resident ‘favourite meal’ is incorporated into the menu. On the day that meal is served the menu board identifies which resident’s request is being provided that day. Residents requests (generally from male residents) for a cooked breakfast of bacon and eggs, are attended to by the cook.  Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. An ad hoc survey on the day of audit with regards to satisfaction with the days meals, had all favourable responses.  There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the FM. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission, residents are initially assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.  In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident’s condition changes. Interviews, documentation and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.   All residents have current interRAI assessments completed by eight of 16 RNs/trained interRAI assessors on site. InterRAI assessments are used to inform the care plan. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | All care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | 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 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 care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| 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 provided by three trained diversional therapists, two recreation assistants and several residents from the village, whose spouses reside in the care facility.  A social assessment, history and discussion is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Families assist in formulating the residents ‘life story’, to enable the staff to become familiar with the resident’s lifestyle prior to residing at Parkwood Retirement Village.  Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated regularly and as part of the formal six-monthly care plan review.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include the weekly men’s club, trips to places of interest for residents, outings to attend community group meetings (e.g. stroke club, singing groups, music group), attend local concerts, visits to social events at other facilities, baking, making preserves, café club, visiting entertainers, knitting group, quiz sessions and daily news updates. The activities programme is discussed at the minuted residents’ meetings, run by the resident’s advocate, and minutes indicated residents’ input is sought and responded to.  Resident and family satisfaction surveys demonstrated satisfaction. Satisfaction with activities is discussed after each event, as recognised in a previous continuous improvement initiative that remains in place. Information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs. |
| 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 any change is noted, 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. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care (e.g. as observed in wound care, behaviour and pain management). Short term care plans were consistently reviewed for acute events such as infections, pain, and weight loss. Progress is evaluated as clinically indicated and according to the degree of risk noted during the assessment process.  Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or CM or one of the three charge nurses, for each area, sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to the psycho-geriatric assessment team, the wound care nurse specialist, respiratory and vascular outpatients. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.  Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. All chemicals are delivered to the maintenance area where they are checked, logged and delivered to the appropriate areas as needed. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.  There is provision and availability of protective clothing and equipment and staff were observed using this. |
| 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 (expiry date 18 May 2019) is publicly displayed.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe, and independence is promoted.  There are a number of external areas that are safe, well maintained and appropriate to the resident groups and setting. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | All rooms have their own ensuite bathrooms. Appropriately secured and approved handrails are provided in the bathrooms, and other equipment/accessories are available to promote residents’ independence. A number of additional toilets are also available around the facility. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms are very spacious and provide single accommodation as well as a number of double rooms for couples if required. The rest home rooms are all individual apartment style, with small lounge areas and kitchenettes. Rooms are personalised with furnishings, photos and other personal items displayed.  There is room to store mobility aids and wheel chairs either inside apartments or in a storage room in the hospital wing. Mobility scooters have charging facilities outside rooms in the wide corridors. Staff and residents all reported satisfaction with the accommodation, especially the rest home apartments. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. There are two dining areas and a large lounge in the rest home and another in the hospital wing. There is also an activity room and a “quiet room”. These areas are spacious and enable easy access for residents and staff. Residents can also access a number of smaller areas and alcoves for privacy, if required. Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is undertaken on site in a dedicated laundry. Care staff and the dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Handwashing of delicate items is done by the laundry staff.  There is a small designated cleaning team who have received appropriate training. These staff have completed all relevant chemical and housekeeping training, as confirmed in interview of cleaning staff and review of training records. Chemicals were stored in a lockable cupboard and/ or store rooms and were in appropriately labelled containers.  Cleaning and laundry processes are monitored through a comprehensive and regular internal audit programme. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 17 March 2006. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being earlier in the month of the audit. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, stretchers, tools ,medical supplies, ladders, night lights and gas BBQ’s were sighted and meet the requirements for the 78 residents. A 30,000 litre water storage tank is located in the complex and there is a generator on site. Emergency lighting is regularly tested.  Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and cameras are installed at all main entrances. Staff all have walkie- talkies for communication and in case of any security issues. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden or small patio areas. Heating is provided by gas and water boiler systems with radiators in each room and communal areas. A large gas fire is located in the main lounge. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Parkwood Lodge provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at management level with input from the FM, infection control committee, external infection control advisory service and the infection control nurse and microbiologist at the CCDHB, if required. The infection control programme and manual are reviewed annually.  The RN is the designated infection control nurse coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported daily at handover, monthly and tabled at the management meeting, RN meetings and staff meetings and two monthly at the infection control committee meetings. Infection control statistics are recorded manually and compared against previous infection data. The organisation’s FM is informed of any IPC concern.  Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has appropriate skills, knowledge and qualifications for the role, and has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from the community laboratory or an external IC advisory body can be sourced if additional support/information is required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The IPC policies are provided by an external advisory body and reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. |
| 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 of infections at Parkwood Lodge 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 handover, to ensure early intervention occurs.  The ICC reviews 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 via management, RN and staff meetings and at staff handovers. Surveillance data is recorded on the infection data sheet. Graphs are produced that identify trends for the current year, and comparisons against previous years. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | 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 provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her role and responsibilities.  On the day of audit, three residents were using restraints. There were no current residents using enablers, which staff reported would be the least restrictive and only used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.  Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval group, made up of the coordinator, the GP, an RN and the clinical nurse leader, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents’ files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.  Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint is part of the plan of care. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator’s involvement, and input from the resident’s family/whānau/EPOA. The restraint coordinator in interview described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident’s safety and security. Completed assessments were sighted in the records of residents who were using a restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members. This includes the use of sensor mats, low beds and laser sensors.  When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.  A restraint register is maintained, updated regularly and reviewed at each restraint approval group meeting held three monthly. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record. Monthly reports are submitted to the quality committee.  Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraint is to be minimised and how to maintain safety when in use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Review of residents’ files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, three monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.  The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Three monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and clinical staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the coordinator confirmed that the use of restraint has been at a consistently low level over the past year. |

# 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.

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| 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | In 2012 Parkwood Lodge identified the need to improve the delivery of end of life care and support to residents and their families. A group of eighteen RNs, enrolled nurses and experienced caregivers completed the Hospice New Zealand Fundamentals of Palliative Care Programme. Since then it has been acknowledged that Parkwood Lodge provides a high level of care for residents referred from Mary Potter Hospice at the end of their life.  In 2016, the service identified the need to ensure all care staff Parkwood Lodge had access to training in palliative care/end of life care. RNs who had already completed the fundamentals of palliative care were given the opportunity to attend the more advanced master class workshops available through Hospice New Zealand. All new RNs to the service are given the chance to complete the 10 learning packages provided by Hospice New Zealand. RNs who have completed the fundamentals of palliative care package are given the opportunity to attend the more advanced master classes. One RN has this year completed a week long ‘palliative care link nurse programme’, working alongside other RNs in the inpatient unit. Another RN has applied to complete the programme and is awaiting confirmation of a start date. RNs attend the quarterly palliative care link nurse meetings held at Parkwood Lodge, enabling all care staff to also attend. Two of the RNs have completed a Post Graduate Diploma in Palliative Care.  Since 2016, caregivers have had the opportunity to attend palliative care for caregivers and advanced palliative care for caregivers training. Four attended the basic programme in 2016 with three attending the advanced programme. In 2017 five attended and this year another four, with four booked for 2019. All RNs employed at now have fundamentals of palliative care qualifications, with 12 attending masterclasses this year. In 2017 two of the Diversional Therapists attended a study day on diversional therapy in palliative care.  Evaluations have identified positive feedback from caregivers regarding their confidence around providing palliative care and improving the standard of palliative care they are able to provide. There is positive feedback from RNs regarding their competence to deliver high quality care, and the confidence that they have the support of care staff who have the skills and knowledge to deliver the care required. There is positive feedback from the Mary Potter Community support team, regarding the high-quality palliative care provided by Parkwood Retirement Village. Feedback from the visiting gerontologist is also positive around the high standard of care provided. Acknowledgement from residents’ families regarding the high-quality care provided in the last days of a resident’s life reflects this. | Parkwood Lodge has improved the skills, knowledge and experience of its staff in the provision of end of life care and support to residents at the facility. This is supported by evidence from family members, staff, training records and specialist service providers. Evidence verifies a reduction in the number of residents requiring transfers to hospital or hospice for additional end of life care. |
| Criterion 1.3.12.1  A medicines management system is 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. | CI | In September 2017, medication errors at Parkwood Lodge were noted to be increasing, specifically around controlled drugs and medications administered by the RN. There had been an increase in the number of residents on controlled drugs. One of the repeated errors was Fentanyl patches being forgotten or not being replaced on the correct day. Staff identified lack of attention, increased workload, and the increase in the number of controlled drug medications needing to be double checked and signed out, as factors in the errors. Several initiatives were trialled around improving the practices of RNs around medication management including the introduction of an electronic medication management system.  Intensive staff training was undertaken to ensure all medication competent staff were skilled in their management of the electronic system. Initially a small number of errors still occurred when new residents came in, however this has resolved with all residents’ medications being entered onto the electronic record. A daily check of Fentanyl patches is made by the RN and recorded in the electronic record. Results of medication error analysis shows a marked reduction in controlled drug errors since the implementation of the electronic system. | A continuous improvement initiative to address an increasing number of drug errors, by the implementation of an electronic medication management system has resulted in a marked reduction in medication errors. |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | A quality initiative previously identified at Parkwood Lodge remains in place and has been expanded. The activities programme aims to continually improve the activities provided to best meet the needs of the residents. Planning sheets continue to be used, to identify the actions required to ensure an event is successful. Risks are identified, as are strategies to manage the risk. Following the activity there is an evaluation to assess the level of satisfaction with each event provided. The results of the findings are incorporated into the next event.  During an early 2018 evaluation of several activities the men expressed a desire to have activities for men, with public speakers, bowls and more physical activity. The men’s club was introduced and runs daily once a week. The women requested more painting and knitting. A communal painting group and knitting group was introduced. New activities also include the café. A café is set up, residents can order coffee or tea and food items (cakes, sandwiches and savouries) which are provided by the kitchen. Bone china cups and small table settings encourage residents to help themselves, request favourite food items and mingle in small groups – all of which contribute to enhanced communication. A visual entertainment area has opened, with DVDs, CDs and books available for residents to use. A large screen TV with surround sound was purchased. | The activities programme at Parkwood Lodge strives to continually improve to best meet the needs of the residents. The facility provides an expansive range of activities, both in and out of the facility that are resident initiated. Pre-planning of activities occurs to identify any risks. A review occurs following the activity with analysis and evaluation of residents’ satisfaction. Findings from the residents’ review of the activity are incorporated into the next event or the event may not be repeated if it was not enjoyed.  A request by residents for the activities programme to include several additional activities has been responded to. Graphs evidence an improvement in attendance at the activities being offered because of responding to these requests, as well as greater levels of satisfaction following the activity. |

End of the report.