# The Village Palms Retirement Village Limited - The Village Palms

## 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:** The Village Palms Retirement Village Limited

**Premises audited:** The Village Palms

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

**Dates of audit:** Start date: 14 August 2018 End date: 15 August 2018

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 63

# 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

The Village Palms is an aged care facility that provides rest home and hospital level care for up to 68 residents. A group of shareholders own the facility, a board of directors govern the service and a nurse manager, a quality manager and a clinical manager manage the service. This is the first year of operation of this facility and although there were some initial difficulties these have since been resolved. The service was operating efficiently and effectively at the time of audit. Positive feedback about the level of care and services provided was verbalised during interviews with staff, residents and family members.

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 and two general practitioners.

An area of continuous improvement has been acknowledged following an initiative that has seen residents provided with more meaningful activities that have contributed to an increase in their levels of mobility. Two areas requiring improvement include the need for the menu to be approved to ensure nutritional requirements are being met and for implementation of the proposed staff training and education programme.

## 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. |

As part of the admission process, residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code). These were observed to be applied in day to day care. Services are provided that support personal privacy, independence, individuality and ensure dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was reported to be effective. There is access to interpreting services if required through the district health board (DHB). Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs, according to appropriate policies and procedures that are in place. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents’ needs.

The complaints process is made known to residents and family members. A complaints register is maintained and included evidence that complaints are followed up to satisfactory resolutions within required timeframes.

## 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. |

A strategic business plan described the scope, goals, values, mission, direction, objectives and action plans for the organisation. One of the directors on the board who maintains close oversight of the management of the facility provides regular monitoring reports to the board. A separate quality and risk management plan is in place. There is an experienced and suitably qualified person currently managing the facility.

Policies and procedures support safe service delivery and were current. The quality and risk management system includes collection and analysis of a range 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, analysis of the data occurring and quality improvement opportunities taken. Actual and potential risks, including health and safety risks, are identified and mitigated.

Human resources processes that cover the recruitment, appointment, orientation and management of staff were based on current good practice. A proposed systematic approach to identify and plan ongoing staff training has been developed and delivery has commenced. An annual individual performance review system is in place.

Staffing levels and skill mixes ensure staff are rostered according to a pre-determined template. These are planned in a manner intended to ensure the changing needs of residents are met.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained in using an integrated file.

## Continuum of service delivery

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

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents’ needs on admission and an initial care plan is formulated until an interRAI assessment is completed and a long-term care plan is developed. Care plans are individualised, based on a comprehensive range of information from the resident, family, needs assessment and discharge summary and include any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. The programme is well attended and well supported by management.

Medicines are safely managed and administered by staff who are competent to do so, using an electronic system.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed.

## 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. |

Waste and hazardous substances are being managed appropriately. Staff have access to and were seen to use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite, and alongside cleaning services, is evaluated for effectiveness.

The facility has a current building warrant of fitness, is being well maintained and ongoing monitoring systems are ensuring fire safety and equipment checks are occurring according to the schedules. Electrical equipment is tested as required. Communal and individual spaces enable privacy as residents choose and are spacious. External areas are accessible, safe and provide shade and seating.

Emergency planning systems are well established and emergency supplies and suitable equipment is available. Staff have access to training on the use of this equipment. Regular fire evacuation trials are undertaken. The call bell system is operating, and residents reported staff respond in a timely manner. Security systems are in place and all communal areas have windows that enable natural light and ventilation.

## 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. There were no enablers and one restraint in use at the time of audit. Comprehensive assessment, approval and monitoring processes for restraint management were being implemented with regular reviews occurring at both the individual and organisational levels. Documentation reviewed, and staff and management reports, confirmed the service provider understands that use of enablers is voluntary for the safety of residents in response to individual requests.

## 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 trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed when needed and to supplement education.

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, and results reported through all levels of the organisation. Follow-up action is taken as and when required. No recent infection out breaks were reported.

## 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** | 1 | 47 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 1 | 98 | 0 | 2 | 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 | The Village Palms has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Residents are informed of the Code on admission. 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 annual training. A session was held on the Code on the 16 March 2018 as was verified in training records. |
| 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 understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff stressing the need for full and complete explanations. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation’s standard consent form for outings, photos, and transfer of medical notes. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident’s record. The role of the GP in determining the level of competence to provide consent is documented in the policies and procedures. Staff were observed to gain consent for day to day care such as knocking before entering a resident’s room. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The advocacy policy notes the role of a support person, especially when a complaint has been made. Advocacy information is given to the resident on admission with additional information available at reception. Staff are aware of the residents’ right to have a support person if a family member is not available. |
| 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 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. Some residents have maintained their family GP and visit their medical rooms.  The facility has unrestricted visiting hours and encourages visits from residents’ family 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 compliments and 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.  The complaints register is in an electronic format and commenced 6 December 2017. A review of the 21 complaints in the register show that all except two of the documented complaints have been followed up, investigated and feedback provided to the complainant within the expected timeframes. The two recent outstanding complaints are still under investigation. There were also two examples of the complainant not having agreed or responded to the resolution provided; however, on investigation there were limitations on any further actions that could have been taken by the service provider.  Action plans described any required follow up and there was evidence that improvements have been made where possible. The nurse manager is responsible for complaints management and follow-up, while the quality manager oversees the quality improvement opportunities aspect in consultation with the nurse manager. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. A person interviewed during the audit informed a complaint had been lodged that day. The person was advised of further options available. On investigation there was evidence that the concerns expressed were currently under review. The manager advised that options for solutions are to be offered to this person and the follow-up will occur in the usual manner.  There were no Health and Disability complaints under investigation for this service provider. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission process and discussion with staff. The Code is displayed in the reception area and outside the nurses’ station, together with information on advocacy services, how to make a complaint, 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 confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff were observed to maintain privacy throughout the audit. All residents have a private room or share a room with their spouse.  Residents are encouraged to maintain their independence by being active. Staff seek areas where they can see potential for improvement in residents’ physical ability and help the residents to set a goal (e.g. walking around the facility). Care plans 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. There was evidence that residents participated in the formulating of their individualised 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 was confirmed to occur during orientation and annually. Family interviewed stressed that they had never witnessed inappropriate behaviour from staff or other residents. |
| 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 is currently one resident who identifies as Māori but has declined to have a Māori care plan (as documented in the person’s file). The policy includes ways of eliminating barriers for admission, includes notes on the importance of family/whānau consultation, describes the four principles of Te Whare Tapa Wha, notes all people who identify as Maori need to have a designated key contact person to be involved in care plan consultations and other key care areas where cultural issues require support/clarification. There is a link to te reo Māori words and a glossary of terms. There is a list of generic cultural points to be aware off regarding care interventions. A list of Māori health providers/community links is provided. Education on cultural safety took place 16 March 2018, for which attendance records were sighted. |
| 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. Information was gathered at admission including resident’s personal preferences, required interventions and special needs and these were included in care plans reviewed, for example which church service they would like to attend. Residents confirmed during interview that they were happy with the way their needs were 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 they had not witnessed any discrimination, harassment or exploitation and felt safe living at The Village Palms. Staff are guided by policies and procedures and could explain the process they would take if they suspected any form of exploitation in the facility. Human Rights and non-harassment policy defines the terms for both residents and staff and reminds staff of confidentiality and that personal information is not to be placed on social media. All registered nurses (RNs) have completed the Code of Conduct through the Nursing Council of New Zealand. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The Village Palms encourages and promotes good practice through evidence-based policies and education around the admission process so that consistency is maintained. Referrals are sent to appropriate specialist services including a dietitian and a wound care nurse as required. The General Practitioner (GP) expressed that the service has sought prompt and appropriate medical treatment and were responsive to medical requests.  Staff interviewed confirmed that management support external education. Education sessions utilise a variety of providers including, the palliative care nurse, Eco-lab, physiotherapy, fire safety, pharmacy, quality manager, nurse manager and RNs. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and staff expressed that management were approachable and used an open-door policy. This was also observed in adverse event forms, with relatives informed in a timely manner according to their preference. The family/whānau reporting page was current. On admission, family are asked what contact they would like, for example call after GP visit, notification of all injuries or only major events.  Interpreter services are available through the DHB but have not been required due to a multicultural staff. Signage is available on residents’ doors if hearing/sight impaired. |
| 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 2017–2018 business plan includes the mission statement which refers to total care, improving independence and maintaining respect, dignity and privacy for residents. An outline of the core values and vision include holistic care, empathy, respect, a high quality environment and excellence in customer service with the intention to achieve the mission statement and maintain a continuous quality improvement system that identifies opportunities for improvement. The plan includes goals, strategies and key performance indicators under headings of internal processes, learning and growth and financial.  An operator of the service, one of the owners, was interviewed and informed that The Village Palms comes under the parent company of Merivale Willowlea Holdings Limited for which there are four directors. With significant changes under way, the board is currently meeting two weekly, although more formal meetings are held monthly. Formerly the board met two monthly. The operator reports to the board of directors and although copies of the reports were unavailable at audit, she described the topics covered and the type of reports provided to them. At present the operator is working alongside and supporting the nurse manager, who has only been in the role for approximately four months. The operator informed that going forward the nurse manager will independently provide reports for the board.  The facility opened late 2017, and for a period early in 2018, there was disruption when a number of new admissions coincided with several management team changes. A new nurse manager and a quality manager were employed in April 2018 and this team has worked at ensuring the requirements of the standards and the contract are being met. At the time of audit, the situation was stable, and staff acknowledged the multiple positive changes that have occurred and expressed appreciation for the support being provided.  The nurse manager was interviewed, and her personnel file was reviewed. This person is a registered nurse with a current annual practising certificate. In addition to managing her own company for six years, she has had extensive experience in the aged care sector in a variety of service delivery, education and managerial roles. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements. Whilst currently undertaking level five of the Business Management Diploma, she keeps up to date with changes by attending a range of external education opportunities around management, leadership and clinical topics and maintaining competencies for medicine administration and wound care, for example.  The service holds contracts with the District Health Board and the Ministry of Health. On the day of audit, 32 people were receiving rest home level care and 25 hospital level care under the Aged Related Residential Care Agreement (ARRC), two of whom were under 65. Six other people were funded via the Young Persons with Disabilities (YPD) contract, five for hospital level care and one for rest home support. |
| 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 | One of the owners advised that in the absence of the nurse/facility manager, the manager from another aged care facility will take over the management aspects and carry out specific required duties under delegated authority. The clinical coordinator will be responsible for ongoing clinical decision-making and able to take responsibility for any clinical issues that may arise. Since the nurse manager commenced in April 2018 she has not had any absences. |
| 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 assurance and risk management system, which links to the strategic business plan and has the principles of continuous quality improvement integrated into it. It lists related legislation, use of the quality framework of ‘Plan, Do, Study, Act’, includes quality objectives, a quality strategy, continuous improvement, quality coordination and an annual performance improvement plan. Other components are management of complaints and incidents, a regular patient satisfaction survey, monitoring of clinical incidents including infections and restraint monitoring and policy reviews.  Policies available cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Documents are based on best practice and were current. These are developed in draft by a contracted nurse management consultant and finalised and ratified by the management team of the service. The document control system is consistent with the policy and ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The quality and risk management team, which meets monthly, consists of the quality manager, the nurse manager, the clinical coordinator, the Young Persons with Disabilities coordinator and the operator. Only three sets of quality and risk management meeting minutes were available, as the quality system required revitalising when the current nurse manager and quality manager commenced. Those sighted confirmed review and analysis of quality indicators is now occurring and that related information is reported and discussed at the quality and risk meetings. Reports on the monitoring and review processes of the health and safety programme were evident, as were infection control updates. Staff informed they are updated on any proposed changes or outcomes of incidents for example, at the regular staff meetings and through handovers.  A comprehensive internal audit matrix that includes a range of internal audit tools was available and was being implemented. Relevant corrective actions are developed when required. Corrective actions had been collated into a log and these are being progressively addressed and closed out. Resident and family satisfaction surveys are scheduled to be completed annually. A recent residents’ survey had a strong focus on food and information from this is being integrated into a wider review for the improvement of food services. An activities survey is underway, and a family survey is planned for release in October.  The risk management schedule notes criteria, current risk category, area of risk identified, current controls in place, person responsible for control implementation and review process. These cover environment and equipment safety, resident safety, outside contractors, vehicles, adverse events and emergency preparedness, financial, confidentiality, staffing, catering and food services and legal liability. The nurse manager and the quality manager, both of whom have completed education on the Health and Safety at Work Act (2015) described the processes being used to implement the risk management plan. A matrix provides direction for additional categorised monthly risk reviews. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the quality manager. Benchmarking is undertaken through access to data and information from other similar services throughout New Zealand. Such data is discussed at the four to six weekly quality and risk management meetings and corrective action and/or quality improvement opportunities are identified. These discussions were evident in meeting minutes available for the past three months and in corrective action logs.  The nurse manager described essential notification reporting requirements, including for pressure injuries. She advised that to her knowledge, there have not been any significant events, or essential notifications since the facility opened. However, she did advise that in April 2018 because of a large volume of admissions, systems required consolidation and therefore The Village Palms, in consultation with the DHB, advised they would abstain from new admissions until the new Nurse Manager was appointed and issues of concern resolved. This restriction is no longer in place. |
| 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. | PA Low | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes qualifications checks when new staff are employed and annual checks of practising certificates for all health professionals who assist residents in any way.  A sample of staff files were reviewed and confirmed that the organisation’s policies are being consistently implemented and records are maintained. Reviews of applications, initial interviews, two referee checks, police vetting and signing of confidentiality agreements, position descriptions and employment agreements were evident.  Staff induction and orientation includes a general orientation followed by additional orientation for necessary components specific to the role. Not all staff have undertaken orientation; however during interview they reported that the orientation process they undertook prepared them well for their role. Senior staff contribute to the buddying process, which varies according to the new staff person’s previous knowledge and experience. Since her employment, the nurse manager has been ensuring the orientation process is completed by all new staff.  Continuing education, including mandatory training requirements, has been planned and is documented in a detailed schedule to occur over the upcoming twelve months. The nurse manager has developed a plan that will enable caregivers to complete or commence a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. Two registered nurses are assessors for the programme.  Not all staff records reviewed included documentation of completed orientation checklists, despite previously employed staff being required to undertake this retrospectively. Likewise, there were gaps in records for mandatory staff training and the three-month performance appraisals. These issues have collectively been raised in a corrective action under criterion 1.2.7.5. |
| 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). This document states that staffing levels will be determined by the nurse manager in conjunction with information from the clinical coordinator, taking into consideration the assessed needs (acuity) of residents and the associated roles, responsibilities and levels of experience of staff. The nurse manager confirmed staffing levels may be adjusted dependent on acuity and that if a rest home person becomes unwell then, for staffing purposes, they are transferred onto the hospital list until they improve, or a reassessment is undertaken.  A detailed roster template is in an electronic system called ‘time target’; however, there is still a dual system in place as the service provider transitions from hard copy to electronic. The nurse manager informed she is available afterhours for on call requirements and receives assistance from the clinical coordinator as required. An availability staff recording sheet enables staff wanting additional shifts to indicate this and they will be considered for these when a person goes on leave or is unable to undertake a shift. This system has markedly reduced the use of agency staff who are less familiar with residents. Auxiliary staff including cleaners, laundry assistants, diversional therapists and managers, for example, complement the nurses and care staff.  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 four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence when indicated.  All registered nurses have completed a modified first aid training that includes cardio-pulmonary resuscitation, and all have a competency in medication management. Hence there is always a person on duty with these requirements. If a level four caregiver is allocated for the medicine round, then this is visible on the roster. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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 varied allied health service provider (e.g., physio, dietitian, podiatrist), notes. This includes interRAI assessment information entered into the Momentum electronic database. 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.  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 | The admission process is clearly laid out in the policies and procedures. The process includes the admission agreement and an admission checklist as well as a welcoming tour of the facility, residents’ room, menu sample, time frames and monitoring.  Once a potential resident, assessed by the Needs Assessment Service Coordinator (NASC) Service and level of care has been identified, the family are able to look for a suitable facility. The family are invited for a tour and receive an information pack including the Code and Advocacy pamphlets.  On the day of admission, a RN is assigned to the resident for the day, to welcome new arrivals, get paperwork signed, and gather information for an initial care plan. A facility tour and introduction to staff and other residents follows. Families and residents interviewed reported that they received sufficient information and felt welcomed.  Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. A detailed initial care plan was formulated. Pharmacy, GP, kitchen and laundry providers were informed of the new resident. |
| 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 DHB’s ‘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/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. A verbal handover via telephone occurs for residents transferring to another facility. All referrals are documented in the progress notes, according to policies and procedures. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The GP reconciles medications during the first 24 hours after admission and ensures they are charted on ‘1chart’.  A safe system for medicine management (‘1chart’ 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. The Drug competency register was sighted.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN on night duty checks medications against the prescription and adds the pack onto ‘1chart’. The GPs expressed satisfaction with the system. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request, including holding in-service education sessions.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. Specimen signatures were sighted.  The records of temperatures for the medicine fridge reviewed were within the recommended range.  Good prescribing practices noted included 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 medicine chart. Standing orders are no longer used due to the electronic system.  There were three residents self-administer medications at the time of audit. Appropriate processes were in place to ensure this was managed safely. Assessments, competency and review were signed by the GP. Those residents who self-administer have a safe in their room for storage.  There is an implemented process for comprehensive analysis of any medication errors. No errors occurred since commencement of ‘1chart’. |
| 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. | PA Low | The food service is provided on site by a kitchen team made up of a chef, two cooks and a team of kitchen hands. On the day of audit, a menu from another facility was being used with some alterations. In recent months some complaints have been presented to management resulting in a review of the menu and food management plan. Evidence of resident satisfaction with meals was mixed from resident and family interviews. Resident meeting minutes revealed some dissatisfaction, so a book was established in the dining room for comments to be made and is reviewed daily. The menu in use, complaints and comments from residents are currently with a dietitian for review. This is in preparation for development and approval of a menu that is suitable for the nutritional needs of the residents at The Village Palms. A corrective action has been raised for this to occur. .  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Christchurch City Council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. The kitchen was clean and tidy, rotation of stock, dating of items and appropriate storage were all observed. Food was prepared in the main kitchen for ground floor occupants, and bain-maries were used to transfer food to the first floor.  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 and allergies are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is available.  On the day of audit, residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| 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 | The nurse manager interviews potential residents and assess the suitability of The Village Palms for their care. Things to be considered are acuity of care, staff to resident ratio, if there are any special needs, and if their needs would best be meet there. A record is kept of any decline and documents filed. Should a resident’s needs change they are required to be reassessed by the NASC. A new placement is then found with assistance from the NASC. Family are supported in this process. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Assessments are completed using a variety of validated nursing assessments such as Coombes, Braden, nutrition profile and pain scale. These combined with interRAI assessments and triggered information are used to formulate the long term care plan. Files reviewed showed input from activities, RNs, and care staff. All residents have a current interRAI assessment since the nurse manager was appointed, with a plan to bring all assessments into line with the admission date which had not previously been happening. Residents confirmed that they had been involved in their care plan. Family said they were asked if they felt goals had been met which was evidenced in the evaluations. Copies of the latest needs assessments for residents on the YPD contract were seen in the files reviewed and had been completed within the last year. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed reflected the needs of the resident and appropriate interventions to meet these. Needs identified by the interRAI assessment were incorporated in the writing of the plans.  Residents and family acknowledged that they were involved in planning care.  Long term care plans are made up of safety/risk, mobility, continence, diet, medication, pain, sleep/comfort, intimacy, communication, cognitive function, behaviour management, respiratory/cardiac, spiritual/cultural, skin/pressure risk, with input from relevant staff. Any change in intervention is documented and passed on to staff at handover. |
| 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. Residents confirmed that they had input into each day’s care and activities. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The young disabled residents had relevant activities such as swimming, going to gym/life skills. 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. Fourteen rooms have in ceiling hoists, pressure relieving cushions and mattresses were available. The GPs interviewed, verified that medical input is sought in a timely manner, that medical orders were followed, and care is professional. |
| 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. | CI | The activities programme is provided by two qualified teachers. A social assessment and history is taken on admission that ascertains residents’ needs, interests, abilities and social requirements. An interactive programme is held over six days and covers a variety of activities that reflected residents’ goals, ordinary patterns of life, normal community activities as well as individual and group events that provide a meaningful programme for the residents. Discussion is held at resident meetings and feedback given to guide futures planning. Activities include exercises, quizzes, singing, happy hour, bowls, bingo, pampering sessions as well as separate men’s and women’s groups. A continuous improvement rating has been allocated for this standard in response to an activity focused programme being implemented that has since been evaluated. Not only has the project promoted physical activity for the majority of residents and has lifted the mood of some but it has resulted in a reduction in the number of resident falls. |
| 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, according to policy and procedures. As this is a recently opened facility, 14 of the 17 residents’ files had not reached the six monthly evaluation period. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for three infections, four wounds and two urinary tract infections. When necessary, and for unresolved problems, long term care plans are added to the long term care plan. 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 two ‘house doctors’, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to the dietitian. The resident and the family/whānau 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. The two GPs interviewed said they were available after hours especially for residents receiving palliative care. |
| 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. These demonstrated that resident safety is a priority. Appropriate signage is displayed where necessary. Waste is managed according to separation of different types with recycling of cardboard with one contractor, continence waste with another and council collections also occurring for general waste.  An external company is contracted to supply and manage all chemicals and cleaning products. Their representatives provide relevant training for staff and complete audit processes. Material safety data sheets were available where chemicals are stored and staff interviewed knew which products were for which purpose and what to do should any chemical spill/event occur.  There is provision and availability of protective clothing and equipment and staff were observed using these items. |
| 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 with an expiry date 1 November 2018 was publicly displayed. Variable dates for the testing and tagging of electrical equipment are documented in a notebook retained by the maintenance person who is licensed to undertake these checks. Evidence of the records showing calibration checks of bio medical equipment as being current (October 2017) were sighted and the two sets of weighing scales were checked August 2018 and October 2017. The maintenance person also holds records of the checks of mechanical equipment including hoists and wheelchairs, which are completed at a frequency according to a documented schedule.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The environment was hazard free, residents were safe and independence is promoted. An updated hazard register was sighted.  External areas are safely maintained and were appropriate to the resident groups and setting. Verandas provide shade and external doors lead to different types of courtyards and outdoor settings.  There is a transport policy and the facility van has a current registration, warrant of fitness and a first aid kit.  Staff confirmed they know the processes they should follow if any repairs or maintenance is required. Maintenance requests are appropriately actioned. Residents and family members said how much they enjoy the modern, fresh and spacious environment. |
| 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 | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Every resident’s room has an ensuite and there are three extra toilets for residents’ use. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment and accessories are available to promote residents’ independence. Records of hot water temperatures only commenced in May and have been completed monthly since then. Random rooms are selected monthly for checking. A basin is in each ensuite, as is sensor lighting. Wall mounted hand sanitiser is available from dispensers throughout 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. Bedrooms mostly provide single accommodation, although there are some larger rooms which may be shared. There are two husband and wife couples sharing and another couple who choose to share confirmed they have agreed to do this. Rooms are personalised with furnishings, photos and other personal items displayed.  There is room to store mobility aids and wheel chairs in resident’s rooms. Storage rooms for mobility, or other independence promoting equipment are available and a separate indoor park for mobility scooters. Staff and residents expressed pleasure with having so much space and the light environment. |
| 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 and provide residents and visitors with options. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, as preferred. 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 | Updated policies, procedures and work schedules were in place for both cleaning and laundry duties. Laundry is undertaken on site by appointed laundry assistants in a dedicated laundry. Laundry assistants knew the expectations and follow documented processes. Use of the dirty to clean flow was evident. Many of the documented processes have been converted into colour charts to address language barriers for staff. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.  There is a small designated cleaning team who during interview confirmed they have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. The cleaning trolley is locked away when not in use. Observation of the cleaning staff showed they were aware of the need to ensure their trolley is safe at all times. Residents and family members confirmed all areas of the facility were always clean, fresh and kept tidy.  Cleaning and laundry processes are monitored for effectiveness through audits undertaken by the chemical company and through the 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 staff in how to prepare for any disasters, as well as describe 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 1 November 2017 and records of six monthly fire evacuations having occurred in November 2017 and June 2018 were sighted. Fire safety compliance checks are being maintained and signed off. The orientation programme includes fire and security training, although as noted in criterion 1.2.7.5 not all staff have completed these requirements. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ’s were sighted and meet the requirements for a full house of 68 residents and a relevant contingent of staff. These were last checked early on August 2018. Water storage tanks are located underground in the front car park. Emergency lighting is regularly tested.  Call bells with ceiling mounted digital readouts and pager and Vocera (Voice system) read outs alert staff to residents requiring assistance. The call system enables checks of response times at any time and the nurse manager undertakes unannounced checks of these. Both a voice call system and a pager system are in place after it was discovered the voice (Vocera) system did not work in all parts of the facility.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time at night and staff undertake security checks. Closed circuit cameras are in place and staff and apartment residents use remote controlled security tags to get into and out of the gates after hours. |
| 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 and opening external windows. The entire facility has underfloor heating with opportunity to monitor specific areas. A large gas fire in the lounge and dining area provides ambience and warmth as required. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. There is a designated smoking area in an external courtyard. |
| 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 | The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are to be reviewed annually according to policy and procedures, and this is scheduled to be undertaken in October 2018.  Currently the IPC coordinator is the nurse manager with election of officers due next week. The role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the nurse manager and tabled at the quality/risk meeting. Feedback is given via handover to care staff.  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 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 temporary IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role since May. Additional support and information is accessed from the infection control team at the DHB, the community laboratory and the GP as required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. No outbreaks have been reported. |
| 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 infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 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. 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 | Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator as well as external sources such as ‘EBOS’, specialising in wound infection and prevention. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.  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 hotter 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 is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal infections and the upper and lower respiratory tract. The IPC coordinator reviews all reported infections, and these are documented and entered into the computer. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year and comparisons against previous years. These are reported by the nurse manager at quality meetings.  No outbreaks have been reported. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint and enabler use 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. They note that approved restraints are bed rails/sides and waist belts, only for use when all other options have been exhausted. The use of de-escalation techniques and of the importance of managing challenging behaviours is documented.  A definition of an enabler clearly specifies that it is any device or process used voluntarily with the intention of promoting resident independence, comfort and safety. Staff were clear during interview that the resident needs to sign consent to use an enabler and that they are voluntary. There are not currently any enablers in use in this facility. Although two people have had a lap belt attached to their wheelchair since the time their chairs were issued, and they could potentially be used as enablers, both residents confirmed that they are not used as they do not like them. |
| 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 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, the role and the responsibilities. A restraint approval group that involves the nurse manager, the quality manager, the nurse coordinator and other registered nurse input was only established in June 2018. The restraint coordinator informed that although she is currently acting as restraint coordinator this will become one of the roles of the nurse coordinator once that person is more established in their position.  It was evident from review of the minutes of the inaugural restraint approval group meeting that restraint management and safe practice is now being implemented according to the policies and procedures and as per the requirements of the standard. The one person who is currently using restraints has their use described in the care plan. Those in use reflected the least restrictive options have been chosen. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint coordinator described the approval and documentation process. An assessment form for the use of restraints is documented and includes all requirements of the standard. A completed copy of this form was in the file of the one person using restraints. Restraints in use are to ensure the person’s safety and security, which is otherwise compromised due to their medical condition. The assessment form had been signed by the person’s next of kin and included GP authorisation. It clearly states that bedrails are for use when the person is in bed and a lap belt and harness are used when they are in their wheelchair. The assessment process and the relevant form had identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. |
| 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. Sensor mats and lowered beds are in use to avoid the use of restraints. Frequent monitoring occurs to ensure the resident remains safe. Recording forms for monitoring restraint use include the necessary details. Although there were some gaps noted in the two hourly recordings, staff explained that this person requires constant monitoring and is therefore seldom alone due to the nature of their condition and the gaps would mostly occur when he was being occupied by a therapist, or similar. Observations made during the audit confirmed these comments. Progress notes include comments on the use of the restraints for each shift. Access to advocacy is available and all processes ensure dignity and privacy are maintained and respected. Examples of this were also observed during the audit.  A restraint register was implemented in March 2018 and has since been reviewed in June and monthly thereafter. The register was sighted and included details of the resident currently using a restraint. Columns demonstrate that maintenance of the register will ensure sufficient information to provide an auditable record of restraint use will be available.  Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours and the use of de-escalation techniques (4 April 2018). Despite this, an internal audit had identified the need for a workshop on restraint, enablers and de-escalation for new staff and this has already been scheduled for a date in September. Staff interviewed understood 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 the resident’s file who is using restraints showed that it had been approved in March of this year, was formally reviewed in June and is scheduled for a further evaluation in September 2018. The identified risks of the person sustaining bruising and skin tears if restraints are not used are documented and staff confirmed they have been reminded of the correct use of the restraints. Family members of this person were unavailable to interview.  The evaluation covers all requirements of the standard, including the impact and outcomes achieved. The restraint approval group meeting minutes confirmed the policy and procedure was followed and documentation had been 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 coordinator advised that as the restraint approval committee had only recently been established, and she had only been in her role as nurse manager/restraint coordinator for four months, she could not confirm if there had been any other restraints used since the facility opened less than a year ago. It was understood from staff interviewed that until the current person using restraints was admitted in March 2018 there had been no restraints used.  The monthly quality and risk meeting minutes showed that the restraint use reports for May, June and July 2018 have remained the same and identify the one person. These minutes confirmed safe use of the approved restraints and that ongoing monitoring is occurring. There was no other data available for this service provider to be able to provide any further quality review information. |

# 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | A staff training schedule has been developed. Staff confirmed they receive training at least monthly, or more often and only need to ask and they can attend relevant external training. Following the arrival of the new nurse manager in April/May 2018, a training schedule that covers mandatory and special interest topics for at least the next twelve months was developed and implementation of this commenced.  The nurse manager informed that following her appointment she could not find orientation records for all previously employed staff. A process that has required these staff to retrospectively complete the orientation process was introduced. The 37% of staff whose orientation is outstanding have been allocated a date to receive assistance with this.  The nurse manager advised that plans are already in place to ensure applicable staff enrol to participate in their national certificate as soon as all staff have completed the orientation checklists and requirements.  As noted throughout the report, not all staff have completed fire and evacuation training and/or restraint and de-escalation training. There were also gaps of attendance in other mandatory training sessions as the staff education schedule has only been in place since May 2018 and time has been too short to complete the requirements. Documents sighted informed that 64% of staff performance appraisals that the policy states staff are required to complete after the 90-day initial employment period are overdue.  Evidence of the time-framed systems in place to redress the identified shortcomings, has mitigated the risk for this corrective action, thus reducing the risk level of the corrective action from moderate to low. | A review of staff files revealed that some have one or more gaps in their individual training records. Not all staff have completed the required orientation package; attended the required mandatory training for their specific role; enrolled in a national certificate; undertaken fire and evacuation and/or restraint management and not all staff have completed a performance appraisal within the required three-month timeframe following employment. | All service providers are required to complete the orientation package; undertake all applicable mandatory training requirements including fire and evacuation and restraint; enrol in or complete a national qualification, as relevant; and have an up to date performance appraisal.  180 days |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | The meals are being prepared using only the basis of a menu from another aged care facility. Although the menu itself was approved by a dietitian for the other service provider, the current meals being prepared and provided have not all been approved by a relevant professional.  Dissatisfaction with the meals was expressed by residents and family when interviewed, especially the young people. This was also evidenced in resident complaints and resident meeting minutes viewed. A survey was undertaken and a comments book made available. Issues of concern were observed during the audit. The manager informed that the comments, the survey results and a menu are currently with a dietitian; however a menu approved from a relevant professional was not yet in use. | The meals currently being provided have not been approved by a dietitian/nutritionist to confirm that they are in line with recognised nutritional guidelines of the consumers and they are not meeting the personal preferences of the younger people with disabilities. | A menu is developed, and approved by a suitable professional, to ensure that it meets relevant nutritional guidelines all residents and includes the preferences of younger people with disabilities.  180 days |

# 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| 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 | The nurse manager along with activities providers introduced a project to increase the physical activity of the residents as part of their healthy wellbeing. Each resident had their physical potential assessed to see the potential they had to improve. Options for physical activity were increased to cater for all levels of fitness and ability. Three stationary pedal bikes were acquired, a Thai Chi instructor attends three days per week plus staff led this one day, ballroom dance instructor attends weekly, massage therapist weekly, and there is a physiotherapist (physio) exercise programme to strengthen lower legs. Staff and family encouragement increased momentum. A walking programme was developed, around the facility for the less able and on outings to Botanical gardens or the pier for the more mobile.  All but five residents joined the project by their own choice.  Review saw residents gainfully involved in increasing mobility, walking greater distances or using simpler mobility aids (e.g. going from using a walking frame to using a walking stick). Physio updated resident files and set further goals.  Evaluation of the project in August 2018 revealed improved outcomes for residents; their purpose/satisfaction of life had improved and resulted in increased resident safety.  Family involved reported better activity involvement and increase of mood. Activities staff noted increased flexibility and attendance at group exercise sessions.  The physio and staff reported a greater tolerance for exercise, improvement in gait, balance and lower leg strength which improved the transfer of residents.  Fall rates reported to quality meetings showed that the fall rate has steadily decreased. May 2018: 23 falls, June: 20 falls, July: 19 falls, August: 5 falls (at 14 August 2018). | Continuous improvement in relation to the introduction of increased physical activity was evident. This quality improvement introduced at The Village Palms resulted in increased meaningful activities, improved mobility, a decrease in falls rate and better outcomes for residents. Further plans are to introduce more activity initiatives. |

End of the report.