

Lady Joy Home Limited - Lady Joy Rest Home

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](#).

The specifics of this audit included:

Legal entity:	Lady Joy Home Limited	
Premises audited:	Lady Joy Rest Home	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 24 October 2018	End date: 24 October 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:	20	

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Lady Joy Rest Home provides residential care for up to 31 residents. The facility is operated by Lady Joy Home Limited and is privately owned.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with one resident, families, management and staff.

Improvements required from this audit relate to medicine management for boarders and the menu being reviewed by a dietitian.

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.	Green	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 of Lady Joy Rest Home. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission by the clinical nurse manager/owner and thereafter as required.

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

Care for residents who identify as Maori 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.

The clinical nurse manager is responsible for the management of complaints and a complaints register is in place. There have been no complaint investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

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

Lady Joy Home Limited is the governing body and is responsible for the services provided. There is a business plan that documents a vision, direction and goals. Systems are in place for monitoring the services provided.

The owners work in the business; one is a registered nurse and has the position of clinical nurse manager and the other owner is the managing director and is responsible for the overall operation of the facility. The facility has been owned by the current owners for 18 years.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Staff and resident meetings are held on a regular basis.

There are policies and procedures on human resources management. Human resources processes are followed. An in-service education programme is provided, and staff performance is monitored.

A documented rationale for determining staffing levels and skill mixes to provide safe service delivery is based on best practice. The clinical nurse manager and managing director are on call after hours.

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

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.
--	--	---

The organisation works 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 on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

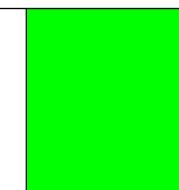
Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. 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 managed by a recreation officer and provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by care staff, all of whom have been assessed as competent to do so.

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 overall satisfaction with meals.

Safe and appropriate environment

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

A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents' bedrooms provide single accommodation. Residents' rooms have adequate personal space provided. Lounge, dining area and alcoves are available. External areas for sitting and shading are provided. An appropriate call bell system and security and emergency systems are in place.

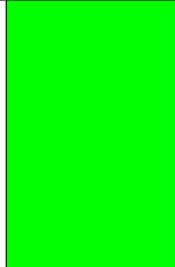
Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site. Cleaning and laundry systems are audited for effectiveness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	---	--

The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard and identifies the use of enablers is voluntary and the least restrictive option to meet residents' needs. At the time of audit there were no residents using restraint or enablers.

Infection prevention and control

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

The infection prevention and control programme is managed by an appropriately trained infection control nurse (who is also the clinical nurse manager) and aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the Wanganui District Health Board.

The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	2	0	0	0
Criteria	0	91	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Lady Joy Rest Home (Lady Joy) has policies, procedures and processes in place 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.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood 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 the organisation's standard consent form including for photographs, outings, and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power</p>

		<p>of attorney (EPOA) 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. The requirement for an EPOA to be in place prior to admission, has been strengthened at Lady Joy.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were 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.</p> <p>Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>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, participation in local club events, visits, shopping trips, activities, and entertainment.</p> <p>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.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and forms available at the front entrance to the facility.</p> <p>The clinical nurse manager (CNM) is responsible for the management of complaints and the complaints register shows two complaints have been received since the previous audit. Staff interviewed demonstrated a good understanding of the complaint process and what actions are</p>

		<p>required.</p> <p>The CNM reported there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in the front foyer. Brochures are available in the reception area, together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>

		an annual basis, as confirmed by staff and training records.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>There was one resident in Lady Joy at the time of audit who identified as Māori, in addition to four staff members. Interviews with the resident and staff, verified 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 in place for the Māori resident, based on Te Whare Tapu Wha, a holistic model of Maoridom. This was developed with input from local Maori advisers.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect 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.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>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) on leave at the time of audit, had left documentation to verify satisfaction with the standard of services provided to residents, and the services timeliness in response to alteration in residents' health status.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. The clinical nurse manager (CNM) has 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</p>

		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	<p>The service encourages and promotes good practice. The CNM/owner works alongside care staff daily ensuring the highest standard of care is provided. The CNM is familiar with all aspects of resident's care and interacts with residents and families in a respectful and knowledgeable manner. Care concerns identified in residents' notes and interviews, identify a prompt responsiveness to areas of concern. Good practice is guided using evidence based best practice policies, input from external specialist services and allied health professionals, for example, a gerontology special interest group, hospice/palliative care team, wound care specialist, services for older people, psycho-geriatrician and mental health services for older persons, and training and leadership of staff.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included a commitment to ensuring the rest home remained homely. Staff have worked at Lady Joy for many years and most of the residents had been known to them prior to coming into the rest home. Staff were observed to be flexible in meeting the needs of the residents.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members 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.

		<p>Interpreter services can be accessed when required. If family were unable to assist, staff knew how to seek assistance. A list of local interpreter services was available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Lady Joy Limited is responsible for the services provided. A facility and organisational business plan 2018 includes a 'SWOT' analysis, direction and goals. The managing director (MD) and CNM work in the business and discuss all matters pertaining to activities at Lady Joy, daily. Both the FM and CNM confirmed this.</p> <p>The clinical service is managed by one of the owners who is a registered nurse with aged care experience who has been in this position since owning the facility. There was evidence in the CNM's file of appropriate ongoing education.</p> <p>The service's philosophy and mission statement are in an understandable form and are available to residents and their family/representative or other services involved in referring residents to the service.</p> <p>The facility can provide accommodation for up to 31 residents. On the day of this audit there were 14 residents assessed at rest home level including one resident under the age of 65 years. Lady Joy has contracts with the DHB for aged related residential care, long term support-chronic health conditions, carer relief, intermediate and a contract with the Ministry of Health for a residential non-aged contract for the resident under the age of 65 years. Six boarders also live in the facility and the managing director advised they have had discussions with the DHB and that the DHB supports this. (See link criterion 1.3.12.1).</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The administrator fills in for the managing director should the MD be temporarily absent. The CNM stated the RN who usually would fill in is now unavailable and they are actively seeking an experienced RN in aged care to fill in for the clinical service should the CNM be temporarily absent. Support is also provided from the house GP if</p>

		needed.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a quality and risk management system that guides the quality programme. Risk management activities are appropriate for the size and scope of the organisation. Quality data is collected, collated, analysed and corrective action plans developed in response to identified issues in a range of ways, including audits, incident/accident reports, complaints, surveys and deficits identified from meetings. Staff meetings are held monthly and provided good reporting of quality data including trended data. Staff stated they discuss trends and corrective actions at the staff meetings and at handover. The CNM demonstrated sound knowledge relating to quality and risk management. Satisfaction surveys for 2018 reviewed showed residents and families were very complimentary of care provided.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice and reference legislative requirements including an interRAI policy. Policies and procedures have footers that showed they were current. New / reviewed policies are available for staff to read and sign off once read. Documentation is also discussed at the staff meetings. Staff interviewed confirmed this. Staff also confirmed the policies and procedures provide appropriate guidance for service delivery and they were advised of new policies / revised policies.</p> <p>The health and safety policy covers all aspects of health and safety management. Actual and potential risks are identified and documented in the hazard register. The register identifies hazards and risks including but not limited to clinical, environmental, staffing and financial and showed the actions put in place to minimise or eliminate risks. Newly found hazards/risks are communicated to staff. Hazards and safety issues are discussed at staff meetings. The health and safety representative is the MD who demonstrated knowledge of health and safety. Staff confirmed they understood and implemented documented hazard/risk identification processes.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. Each resident has a resident untoward event summary form on file. 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 and analysed by the CNM and trends shared with staff through meetings. A month by month summary register is current and staff are provided with month by month graphs. Residents' families were advised of the incident/event on every form sampled.</p> <p>The CNM and MD described essential notification reporting requirements, including for pressure injuries and health and safety issues. They advised there have been two notifications of significant events made to external agencies since the previous audit. One of the events has been investigated by the DHB, with Police and Coroner involvement. Documentation was reviewed which showed a final report was received from the DHB dated 1 August 2018 with a recommendation relating to updating the admission policy. The recommendation has been actioned by the provider.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, police vetting and training certificates.</p> <p>New staff are required to complete the induction programme. They are 'buddied' with an experienced caregiver with constant support from the CNM. The entire process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and yearly there. Staff performance appraisals were current. Annual practising certificates were current for staff and contractors who require them to practice.</p> <p>The education programme is the responsibility of the CNM. Records are held for staff attendance at training sessions and competencies for medicine management and restraint. In-service education is provided for staff and documentation evidenced this is held at least monthly.</p>

		<p>External educators provide some sessions. Staff have current first aid certificates and these were sighted in staff files.</p> <p>Staff are encouraged to complete the Careerforce programme and the CNM is the facility assessor.</p> <p>Staff confirmed they have completed an induction, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented process that determines the staffing levels and skill mix to provide for safe service delivery. Staffing is adjusted including interRAI assessments for acuity and/or occupancy. 'On-call' is provided by the CNM for the clinical service and the MD for non-clinical issues. Rosters reviewed evidenced staffing levels are above the requirements of the Aged Residential Care Contract requirements. Staff interviewed confirmed they can complete their work and residents and families stated there is always staff available in the facility. The CNM and MD work full time and the CNM is interRAI trained. There are dedicated household staff for the laundry and cleaning with staff responsible for any cleaning when the household staff are not rostered on. The MD is responsible for any maintenance that is required. Staff are replaced in the event of planned or unplanned absences. The six boarders are provided with laundry and cleaning services from the household staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used 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.</p> <p>Archived records are held securely on site and are readily retrievable</p>

		<p>using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents requiring rest home care at Lady Joy 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 CNM. They are also provided with written information about the service and the admission process.</p> <p>Residents residing out of the area are required to have documentation in place verifying they require rest home care, and the Wanganui District Health Board (WDHB) has approved the move. This process has been strengthened at Lady Joy.</p> <p>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, authorisations and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner. The service uses their own transfer form 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 to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Documentation verifies the</p>

		<p>resident's family was being kept well informed of the transfer.</p> <p>Processes for the transfer of residents to Lady Joy from one DHB to another have just been updated.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The medication management policy at Lady Joy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>With the exception of the observed practices in place regarding the administration of medicines to the boarders, a safe system for medicine management using a manual 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 assessed as competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by the CNM against the prescription. All medications sighted were within current use-by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There were no rest home residents who were self-administering medications at the time of audit, however appropriate processes are in place to ensure this can be managed in a safe manner, if required.</p>

		<p>Medication errors are reported to the CNM 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.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>The food service is provided on site by a cook. The menu follows summer and winter patterns; however, there is no recent evidence to verify the menu meets nutritional guidelines for older people.</p> <p>A food control plan is in place and was registered with the Wanganui City Council on 8 March 2018. A verification audit took place on 6 July 2018 and an A grade certificate awarded.</p> <p>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.</p> <p>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.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
Standard 1.3.2: Declining Referral/Entry To Services	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

<p>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.</p>		<p>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 CNM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p> <p>Residents requesting transfer to Lady Joy from outside the area, are declined unless all the required approvals have been provided. This has been strengthened at Lady Joy following the investigation by the DHB.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Lady Joy 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.</p> <p>In all files reviewed initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments were completed within three weeks of admission and at least six monthly unless the resident's condition changed. Interviews, documentation and observation verified the CNM is familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by one trained interRAI assessor on site. InterRAI assessments are used to inform the care plan.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>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.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' 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.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents of Lady Joy 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. The GP, via documentation, 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 were available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by a recreation officer, who is undertaking training in diversional therapy.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal</p>

		<p>community activities. Individual, group activities and regular events are offered. Examples included an exercise programme, a range of outings, visiting entertainers, quiz sessions, residents go out for walks, trips into town and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs. A facility van is available for outings, though at present is awaiting repairs. Facility cars or the use of a mobility van service is being used to enable outings in the meantime.</p> <p>In addition to rest home residents at Lady Joy, there are six people residing at the facility, who are boarders. Their presence has enabled a more social atmosphere in the home.</p> <p>Activities are not provided in the afternoon at Lady Joy, as residents initiate their own interest groups or activities. Interviews verified groups of residents meet and interact around similar areas of interest. All were happy with the level of activities provided by Lady Joy.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the CNM.</p> <p>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 CNM. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short-term care plans being consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as a resident's wound management plan, were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>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 CNM sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the wound care nurse, orthopaedic specialists, older persons' mental health services, psychiatric services and palliative care. Referrals are followed up on a regular basis by the CNM 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 taking/sending the resident to accident and emergency in a car or an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Safe and appropriate waste management procedures including hazardous substances are in place and incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation, including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The laundry person demonstrated good knowledge concerning waste and hazardous substances.</p> <p>Protective clothing and equipment including gloves, full face visor and disposable aprons were observed appropriate to recognised risks.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness was displayed that expires on the 16 March 2019. The facility is well maintained both internally and externally. A preventive and a reactive maintenance programme is in place and hot water temperatures are within the recommended range. Testing and tagging of equipment and calibration of biomedical equipment is current.</p>

		There are areas throughout the facility for residents to frequent. The facility surrounds a court yard with gardens, lawns and outside furniture for residents to enjoy. Surfaces, both internal and external are flat with ramps and safety rails leading to the outside. Residents were observed to easily manage with mobility aids.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All rooms are single and there is a mix of shared ensuites (toilets and wash hand basins) and rooms without ensuites. There are adequate showers and toilets located throughout the facility. Locking devices were observed for privacy.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>Resident and families interviewed reported that there were sufficient toilets and showers and that they are easy to access.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is a mix of larger and smaller bedrooms. Bedrooms are large enough to provide personal space for residents and allow staff and equipment to move around safely. Rooms are appropriately furnished and maintained. Residents interviewed spoke positively about their accommodation. There is room to store mobility aids.</p> <p>Five of the six boarders occupy bedrooms at the end of one wing and the sixth boarder has a bedroom at the end of the other wing. The boarders can use their own entry and exit to the facility if they so wish.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Residents have areas within the building to frequent, including dining and lounge areas that are easily accessed by residents. Residents can access areas for privacy if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents and families interviewed reported there are adequate areas for them to access and enjoy.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is washed and dried on site. Cleaning and laundry is undertaken by dedicated household staff. Cleaners and laundry staff demonstrated a sound knowledge of processes. Chemicals are stored securely. All chemicals were in appropriately labelled containers. The company representative visits monthly and provides on-going training for staff. Cleaning equipment and linen bags are colour coded for different uses. Cleaning and laundry processes are monitored through the internal audit process.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The evacuation scheme was approved by the New Zealand Fire Service on 13 September 2004. Fire drills are completed six-monthly. There have been no building alterations since the previous audit. The emergency plan details emergency preparedness. Staff confirmed their awareness of emergency procedures and training has been provided. The orientation programme includes fire and security training. All required fire equipment has been checked and was current.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and a gas BBQ. A portable petrol generator supplies emergency power. A call bell system alerts staff to residents who require assistance.</p> <p>The doors are locked in the evenings and sensor lights are situated externally. Staff also complete security checks.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Heating is either via electric panel heaters or ducted from the ceiling with individual thermostats in the bedrooms. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All residents' rooms have natural light. The service has an external covered area for smokers. Residents and families confirmed the facility is maintained at a comfortable temperature. During the audit, the temperature was appropriate in all areas.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service 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 organisational level with input from the CNM. The infection control programme and manual are reviewed annually.</p> <p>The CNM is the designated infection control nurse (ICN), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and tabled at the quality/staff meeting. Infection control statistics are entered in the organisation's database.</p> <p>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.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICN has appropriate skills, knowledge and qualifications for the role. The ICN has undertaken post graduate 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. The ICN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICN confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and</p>	<p>FA</p>	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p>

<p>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.</p>		<p>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.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>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 ICN and the infection control nurse from the WDHB. 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. An example of this occurred when there was a recent increase in respiratory tract infections.</p> <p>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.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. 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 ICN 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 at quality/staff meetings and at staff handovers. Surveillance data is entered in the</p>

		<p>organisation's infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. An observed high number of skin infections is related to the recurrent chronic skin infections of two residents.</p> <p>A 2016 outbreak of Norovirus included the closure of the facility. Public Health and the WDHB were informed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes a definition, assessment and evaluation and complies with the requirements of the standard. The restraint coordinator, who is the CNM reported the aim is not to use any form of restraint. There were no residents using a restraint or enablers at the time of audit. Staff interviewed demonstrated knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>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.</p>	PA Low	<p>Fourteen rest home residents receive medicines guided by safe medication management guidelines and the contractual requirements of the DHB contract.</p> <p>Six boarders, are receiving care services from Lady Joy in the form of medicine administration. The observed practice identifies actual errors and potential errors in medication management involving these clients. The pre-packaged medication being administered to one client is inconsistent with the on-site medication chart. There is no process verifying the medication charts staff use to guide administration are up to date. The clients visit GPs off site. One boarder’s medication chart was last signed by a prescriber in January 2018. A boarder having a prescribed liquid medication administered by care staff has no documentation verifying it has</p>	<p>The administration of medications to boarders is not being managed in the same manner as rest home residents.</p>	<p>Provide evidence that medication administration to boarders is managed in the same manner as the rest home level clients.</p> <p>30 days</p>

		<p>been administered. Documentation reflects the administration of packed medications only. Staff are administering a number of controlled drugs to a boarder. The controlled drug register is signed in accordance with legislative requirements, however the boarder's administration records do not always record the administration of this medication. A boarder on a varying-dose medication has no documentation on site to verify instructions for the varied daily dose.</p>		
<p>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.</p>	<p>PA Low</p>	<p>Interviews, satisfaction surveys and meeting minutes verify a high level of satisfaction with the meals provided at Lady Joy, however there is no evidence to demonstrate a review of the menu by a dietitian since October 2015.</p>	<p>There is no recent evidence to verify the menu meets recognised nutritional guidelines for older people.</p>	<p>Provide evidence the menu is in line with recognised nutritional guidelines for older people.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.