Lakeside Lodge Rest Home Limited - Lakeside Retirement Lodge

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 Health and Disability Auditing New Zealand 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:	Lakeside Lodge Rest Home Limited
Premises audited:	Lakeside Retirement Lodge
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 February 2019 End date: 26 February 2019
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit: 30	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Lakeside Lodge provides rest home level care for up to 30 residents. On the day of the audit there were 30 residents.

The rest home is owned and operated by the facility manager and the clinical manager. Both owners are registered nurses. They employ an additional registered nurse. The rest home has a high registered nurse to resident ratio with stable staffing. There are established quality and risk management systems in place.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner.

The residents, relatives and general practitioner spoke highly of the care and service provided at Lakeside Lodge. The service has a well-established quality system that identifies ongoing quality improvement.

There is one area for improvement identified, related to care plan interventions.

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.

The staff at Lakeside Lodge ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with families identified that they are fully informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

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.

Two experienced owner/managers have co-owned and managed the facility for 17 years. They are supported by a registered nurse and a stable team of long-serving experienced staff.

There is an established quality and risk management system in place that is being implemented. Quality management processes are reflected in the business plan and risk management plan, objectives and policies. There is a 2019-2020 business plan in place. There is a monthly staff meeting that includes health and safety, infection prevention and control, discussion of quality and risk matters including adverse events.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents were very satisfied with the 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.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All rooms have ensuites with toilets and hand basins and there are sufficient communal showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

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 policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. At the time of the audit, the service had no residents using restraints or enablers. Staff have received training around restraint minimisation and management of challenging behaviours.

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 suitable for a facility of this type. The programme is led by the manager with support from the clinical manager and the registered nurse. The programme is based upon a clear set of policies and procedures that are available to guide staff. The general practitioner is actively involved in the management of residents with suspected infections. Education is provided to staff on an ongoing basis and infection prevention and control is included in the internal audit programme. Infections are monitored, and practice is reviewed every month. Trends can then be identified. There have been no recent outbreaks of infection in the rest home.

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	44	0	1	0	0	0
Criteria	0	92	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with six care staff (one registered nurse (RN), three caregivers and one activities coordinator) confirmed their familiarity with the Code. Seven residents and five family members interviewed confirmed the services being provided are in line with the Code.
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	The service has in place a policy for informed consent. Completed resuscitation forms were evident on all resident files reviewed (six rest home). General consent is covered by a paragraph, named permissions granted, in the admission agreement. All six admission agreements reviewed were signed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney forms are filed in the resident's charts.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Client right to access advocacy and services is identified for residents. Advocacy leaflets are available throughout the facility. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members interviewed were aware of their access to advocacy services.
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	The service has an open visiting policy. Family and friends are encouraged to visit the rest home and are not restricted to visiting times. All residents interviewed confirmed that relatives and friends are able to visit at any time. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. The service has a van, and group outings are provided. Community groups visit the rest home as part of the activities programme.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy and procedure in place, which meets the requirements of the Code. The process is communicated to residents and their families on admission. Complaint forms are readily available. Staff are educated on the complaints process. There have been no complaints made in 2017, 2018 and 2019, year to date. Any resident concerns are actively addressed by the managers. Residents and family members interviewed advised that they are aware of the complaint's procedure.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and advocacy pamphlets are located throughout the facility. On admission, the owner/manager or RN discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. A laminated copy of the code of rights is displayed on the noticeboard in each resident's room. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. The service provides an open-door policy for concerns/complaints. Residents and relatives interviewed identified they are well informed about the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	FA	The facility provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed were able to describe how they maintained resident privacy and promoted resident independence. Staff sign a privacy declaration on employment. The facility manager is the privacy officer and has an open-door policy. Staff

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		attend education and training on abuse and neglect.
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	The service has guidelines for the provision of culturally safe services for Māori residents. There is a Māori health plan. On the day of the audit there was one resident that identified as Māori. The resident was not interviewed. The care (sighted) included cultural interventions. The resident speaks te reo to his family and attends whānau activities in the community. Staff interviewed were aware of specific Māori cultural preferences.
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	The service provides a culturally appropriate service by identifying any cultural needs as part of the interRAI assessment and planning process. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular on-site church services, spiritual visitors and attending other community groups as desired. Staff are provided with ongoing cultural awareness training.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes confirmation of reading and understanding the staff information booklet and house rules. Job descriptions include responsibilities of the position, and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries. Staff were observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Caregivers interviewed could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect.
Standard 1.1.8: Good	FA	The service meets the individualised needs of residents with needs relating to rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of

Practice Consumers receive services of an appropriate standard.		service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. The manager is responsible for coordinating the internal audit programme. Monthly staff/quality meetings and monthly residents' meetings are conducted. There is a regular in-service education and training programme for staff. Staff have a sound understanding of principles of aged care and stated that they feel supported by the owner/manager and clinical manager. Evidence-based practice is evident, promoting and encouraging good practice. An RN is on-call when not on-site. A house general practitioner (GP) visits the facility at least one day a fortnight. The service receives support from the local district health board (DHB). Physiotherapy services are provided on-site as required. A podiatrist is on-site every six-weeks. The service has links with the local community and encourages residents to remain independent. Residents and relatives interviewed spoke positively about the care and support provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy in place. The managers promote an open-door policy and relatives confirmed this is normal practise and that management are always available and approachable. Residents are provided with a range of information on admission regarding the scope of service and any items they have to pay for that is not covered by the agreement. An interpreter is provided as required. Communication with family members is recorded on the incident report forms and in the resident daily progress notes. Relatives sign a communication sheet to inform the service when and under what circumstances they would like to be informed. Twelve incident forms reviewed identified that family were notified following a resident incident. Five family members interviewed stated they were well informed and involved when needed in resident's care. Monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted). Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and can be read to residents who are visually impaired.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	Lakeside Retirement Lodge provides care for up to 30 rest home level residents. On the day of audit there were 30 residents. All residents were being provided with services under the aged residential care agreement. The manager is a registered nurse with a background in mental health. He has worked in aged care since 1996 and has co-owned Lakeside Retirement Lodge for over 17 years. His wife, who also is a registered nurse, is the clinical manager. They both hold current practising certificates.

consumers.		The philosophy, mission, scope and goals of the service are documented in the quality manual and in the information pack that is provided to residents and their families during their admission to the rest home. There is a 2019 to 2020 business plan, quality and risk plan developed which aligns with purpose, mission and values of the business. The manager and the clinical manager have maintained at least eight hours annually of professional development activities related to managing a rest home.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The manager reported that in the event of both him and his wife's (CM) temporary absence, the RN fills the role with support from other long-term experienced staff.
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	A business plan and quality and risk management programme are in place. Quality is monitored through internal audits, adverse event collation and analysis, infection rates, resident satisfaction, and staff retention. Internal audits monitor compliance with policies and corrective actions are implemented where required. Policies and procedures are provided by an external consultant and include interRAI procedures. The policies have been recently reviewed and a system is in place for regular review. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes. Staff have input into the staff meetings, where there is discussion around complaints, compliments, health and safety, adverse events, infection prevention and control, audit and survey results, corrective actions and improvements. Staff interviewed stated they are well informed and receive quality and risk management information such as accident/incident trends and infection control statistics. Staff reported they also receive quality information on trends at handover and through the communication book. There are annual resident satisfaction and family satisfaction surveys and quarterly food satisfaction surveys completed. Suggestions for improvements or trends are identified and actioned. Overall satisfaction was high. The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified. A health and safety programme is in place, which includes managing identified hazards. Health and safety discussion occurs at monthly staff meetings. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.

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	The service collects all incident and accident information reported by staff on a paper-based system. Incident and accident data is collected and analysed monthly and are reported at the monthly quality/staff meeting. Twelve resident related incident forms were reviewed for January and February 2019. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Care staff interviewed were very knowledgeable regarding the care needs (including high falls) for all residents. Discussions with the owner/manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. This has not been required.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources policies have all been recently reviewed and provide comprehensive guidance on recruitment, selection, orientation and staff training and development. Five staff files (one RN, two CGs, one cook and one activities coordinator) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A copy of registered nursing staff and other health practitioner practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. There is an annual education plan being implemented. The manager, clinical manager and RN have completed their interRAI training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The manager (RN) and clinical manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. An RN covers Saturday and Sunday morning shifts, one weekday afternoon shift and one morning shift each week. There are three caregivers on morning shifts (all full shift), two on the afternoon shift (full shift) and two on night shift. An activities coordinator is rostered Monday to Friday, four hours a day. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are always replaced when off sick. The RN reported additional staff are rostered if the acuity increases, Interviews with residents, relatives and staff confirmed that staffing levels are sufficient to meet the needs of residents.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner.
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	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Six admission agreements sighted were signed and dated.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. The yellow envelope system is used.
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	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders in use. There are no vaccines stored on site. The facility uses a paper-based and blister pack system. They would like to move to an electronic system but currently have Wi-Fi 'drop-out' problems. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent caregivers administer medications. Staff have up-to-date medication competencies and there has been medication education in the last year. The medication fridge temperature is checked daily. Eye drops are dated once

		opened. Staff sign for the administration of medications on paper signing sheets. Twelve medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service has two cooks; one works four days and the other, three. There is a kitchenhand on each morning shift. There is also an afternoon cook who works 1200 - 1800. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served directly from the kitchen to the dining room in bain maries. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures have been monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by a contracted dietitian. All residents and family members interviewed were very satisfied with the meals. One resident commented 'I came here for the food'. The food control plan is due for review on 9 October 2019.
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 service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
Standard 1.3.4: Assessment	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.		consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed including the new admission. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) falls risk, pressure injury risk, pain and depression.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions document detail around support needs and provide guidelines for care. Some care plans however have missed interventions around current assessed needs. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family are notified. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently eight wounds being treated. There are no pressure injuries. One non-facility acquired chronic wound has had input from the GP and wound care nurse specialist. There are also photos to show wound progress. Monitoring forms are in use as applicable such as weight, vital signs and wounds.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	FA	There is one activities coordinator who works four and a half hours a day Monday to Friday. There is a volunteer who comes in at weekends to play the piano. The activities coordinator also leaves out games and puzzles. On the days of audit residents were observed going for walks, listening to music and entertainers and playing games. There is a weekly programme on a whiteboard in the lounge. Residents have the choice of a variety of

requirements are appropriate to their needs, age, culture, and the setting of the service.		activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music and walks outside. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. The activities coordinator visits each room first thing each morning. There is an Anglican and Presbyterian Church service held in the facility monthly. On the first weekend of the month there is an interdenominational service. Catholics have a volunteer come in to give communion every Friday. There are van outings weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Fathers' Day, Anzac Day and Chinese New Year are celebrated. The facility has two cats, ducks on the pond and the activities coordinator brings in miniature ponies to visit. There is community input from volunteers, schools, pre-schools, the RSA, a Kapa Haka group and the Wesley college cultural group. The Māori resident speaks fluent te reo Māori but only to family. The resident prefers to stay in the resident's room playing on a lap top but likes to go out with whānau. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held monthly. Residents stated the activity programme was varied and they enjoyed it.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The six long term care plans reviewed (apart from the new admission) had been evaluated by the registered nurses six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. The family members interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist and mental health services for older people. Discussion with the registered nurse identified that the service has access

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		to a wide range of support either through the GP, specialists and allied health services as required.
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	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness which expires 31 May 2019. The manager is in charge of all maintenance. There is a preventative and reactive maintenance programme. Contractors are used when required. The gardener is contracted. Electrical equipment has been tested and tagged. There are stand on scales. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. There is a mixture of carpet and vinyl flooring throughout the rest home. The utility areas such as the kitchen and laundry have vinyl flooring. Ensuites, toilets and communal showers and toilets have nonslip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is a large pond and stream on the property, all safely fenced. These have ducks and eels and the residents enjoy feeding the ducks. There is also a short bush walk around the pond which is suitable for residents with walking frames. There are benches placed along this walk so residents may rest if required. All outdoor deck and courtyard areas have seating and shade. There is safe access to all communal areas. Caregivers interviewed stated they have adequate equipment to safely deliver cares for all levels of care

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	The rest home has 30 rooms with ensuites containing toilets and hand-basins. There are sufficient communal toilets and showers. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if appropriate. There are signs on all shower/toilet doors.
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	All resident's rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
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	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. One lounge opens out onto an attractive deck and the pond. There is a dining room off the kitchen.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic	FA	All laundry is done on site. The laundry is run by designated caregivers. The laundry is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away in the laundry. All chemicals on the cleaner's trolley were labelled. The laundry is kept locked when not in use.

cleaning and laundry services appropriate to the setting in which the service is being provided.		
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency management plans are in place to ensure health, civil defence and other emergencies are covered. Lakeside Lodge has developed a specific plan to provide guidance in the event of flooding. The facility has also raised footbridges over the adjacent stream and relocated retaining walls to manage the increased rain run-off from recently developed sections situated above the facility. In the event of flooding concerns there is an agreement with two local facilities to provide emergency accommodation. Fire and evacuation training has been provided. Fire drills are conducted six monthly. The last fire evacuation drill occurred in October 2018. Civil defence supplies are available. There is alternative gas heating and cooking (1 x BBQs and gas cookers in the kitchen) available. Extra blankets, torches and supplies are available. There is sufficient food in the kitchen to last for three days in an emergency. There is sufficient emergency supplies of stored water available on site. Appropriate training, information, and equipment for responding to emergencies is part of the orientation of new staff. There is an emergency management manual in place. External providers conduct system checks on alarms, sprinklers, and extinguishers. First aid supplies are available. There is a staff member on duty across 24/7 with a current first aid certificate. Call bells were appropriately situated in all communal areas. Each bedroom has a call bell in the bedroom and bathroom and light up outside each room and on two display panels in the nurse's station.
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 bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is an outdoor area where residents may smoke. All other areas are smoke free.
Standard 3.1: Infection control management There is a managed environment, which	FA	Infection control is the responsibility of the manager (RN). A job description documents the position objectives and tasks. The infection control coordinator oversees infection control for the service and is responsible for the collation of infection events. The infection control programme has been reviewed annually.

minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine. There have been no outbreaks.
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 infection control coordinator has attended infection control and prevention education provided by an aged care educator. There is access to infection control expertise within the DHB, wound nurse specialist, public health, laboratory, GPs and external infection control consultant. The GP monitors the use of antibiotics.
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 control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an aged care consultant and have been reviewed in January 2019.
Standard 3.4: Education The organisation provides relevant education on	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Staff complete hand hygiene competencies.

infection control to all service providers, support staff, and consumers.		Resident education is expected to occur as part of providing daily cares.
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	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Any resident who is suspected of having an infection is reviewed by a registered nurse and the general practitioner. Specimens are taken as appropriate and sent to the laboratory and a record of this action is maintained in the resident's clinical record. Results are received, considered and documented. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Trends are identified, and quality initiatives are discussed at staff meetings (minutes sighted). The rest home has continued to maintain a low infection rate since the previous audit. The GP reviews antibiotic use at least three monthly with the medication review. Systems are in place and are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers. There were no residents requiring the use of a restraint or an enabler at the time of audit. Staff receive training around restraint minimisation. All staff are aware that Lakeside Lodge aims to continue their restraint free status.

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)
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Care plans are resident centred and interventions document detail around support needs and guidelines for care. Some care plans however have missed interventions around current assessed needs.	Four out of six files reviewed did not document interventions to support all current assessed needs. However, caregivers interviewed could describe current cares for each file reviewed. (i) A resident with weight loss has no documented weight loss measures other than weigh every four days. (ii) Two residents with pacemakers did not have these documented in the care plan. (iii) One resident whose assessment states has difficulty finding words has no documented interventions for communication.	Ensure all care plans have interventions for current assessed needs documented. 90 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.

No data to display

End of the report.