

Falani Limited - Virginia Lodge

Introduction

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

The audit has been conducted by 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: Falani Limited

Premises audited: Virginia Lodge

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 24 September 2019 End date: 25 September 2019

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
	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

Virginia Lodge provides care for up to 21 rest home level residents. On the day of the audit there were 20 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, the GP and management.

The owner/director has a background in business management and has privately owned Virginia Lodge for two years. He is supported by an experienced nurse manager/enrolled nurse. They are supported by a full-time clinical manager (registered nurse), registered nurses and long-standing staff. Residents and relatives interviewed were very complimentary of the services and care they receive.

The service has addressed the previous certification shortfall relating to monitoring.

This surveillance audit identified no areas for improvement.

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.
--	--	--

A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

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.
---	--	--

The facility manager is responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme was documented. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training were in place, which includes in-service education and competency assessments. Residents, relatives and staff reported that staffing levels are adequate to meet the needs of the residents.

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.		Standards applicable to this service fully attained.
--	--	--

Registered nurses are responsible for care plan documentation. InterRAI assessments and care plans are completed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and families advised satisfaction with the activities programme. The service uses an electronic medication management system. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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.
--	--	--

Virginia Lodge has a current building warrant of fitness and reactive and preventative maintenance occurs.

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.
---	--	--

Virginia Lodge has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service currently has no residents requiring 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.

Virginia Lodge continues to implement their infection surveillance programme. Infection control issues are discussed at both in the infection control and quality/staff meetings. The infection control programme is linked with the quality programme.

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	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register. Three complaints have been received since the last audit; two in 2018 and one in 2019. Documentation and correspondence reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Caregivers interviewed confirmed that complaints and any required follow-up is discussed at staff meetings as sighted in the minutes. Complaint documentation requiring changes to care planning are signed by staff once read. Residents and relatives advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	Comprehensive information is provided at entry to residents and family/whānau. Five residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Both the facility manager and clinical manager were available to residents and relatives and they promote an open-door policy. Incident forms reviewed in September 2019 evidenced that relatives had been notified on all occasions. Four relatives interviewed advised that they were promptly notified of incidents and when residents' health status changed. The registered nurse, caregivers and the diversional therapist interviewed fluently described instances where relatives would be notified. Newsletters are available for visitors at the entrance.

communication.		
<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>	FA	<p>Virginia Lodge provides care for up to 21 rest home level residents. On the day of audit, there were 20 residents including two residents on a short-term intermediate care contracts (DHB) and two residents on a DSS MOH contract and 16 residents on the ARC contract.</p> <p>Virginia Lodge's mission and philosophy is identified in the strategic business plan which is reviewed annually. The 2019 business/quality plan includes goals to achieve full occupancy, continue to achieve a grade 'A' for the food control plan audit, changes to the payroll system, implementing the medimap medication system and continue with the refurbishment of rooms as they become available. The 2018 plan had been reviewed by the facility manager and the owner, and the current plan was developed.</p> <p>The owner lives out of the area and has been the current owner since 1 April 2017. He has a background in business management and human resources. The facility manager (previous owner) has been in the role for four years at Virginia Lodge and has several years aged care experience and is an accomplished enrolled nurse (EN) with a current practicing certificate. The facility manager is supported by a full-time clinical manager (who lives on site), and three registered nurses. The clinical manager is a registered nurse with experience in aged care and Hospice. One registered nurse works 32 hours a week and there are two casual registered nurses.</p> <p>The facility manager has attended at least eight hours of education within the last year related to managing a rest home including an interviewing staff course (8hrs) and attends the DHB Aged Care Service Providers forums quarterly. The clinical manager has completed the interRAI course and has attended a leadership and management course.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Virginia Lodge is implementing a quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. These are checked by an aged care consultant, who reviews policies to ensure they align with current good practice and meet legislative requirements.</p> <p>Virginia Lodge continues to gain feedback and 'Thank-you' cards and emails from relatives around the previous continuous improvement around good practice during end of life supports.</p> <p>Monthly accident/incident reports, infections and results of internal audits are completed. Quality matters are taken to the monthly combined staff/quality meetings which includes health and safety and infection control. Resident meetings occur six-weekly.</p> <p>An internal audit programme is in place that includes aspects of clinical care. Issues arising from internal audits are either resolved at the time or developed into a quality improvement plan. The closure of corrective</p>

		<p>actions resulting from the internal audit programme was recorded, signed off by the facility manager and signed by staff who were not present at the meeting. Quality/staff and resident meeting minutes include an accurate reflection of the discussion/outcomes of the meetings, including follow-up to actions taken as matters arising. Record of monthly risk identification, and quality indicators is maintained and discussed at the monthly meetings and a copy is filed with the completed monthly internal audits.</p> <p>The owner and the facility manager meet at least quarterly, minutes of the meeting are documented and signed.</p> <p>A resident survey has been completed annually which in 2018 had 18 responses and showed overall satisfaction with the service particularly around activities and food services. In 2019, the residents survey identified 100% satisfaction with the food services, and overall satisfaction with all other areas of the service. The annual relatives survey went from 96% satisfaction to 100% in 2019. There is an annual staff survey completed which shows overall staff are happy at work, changes were made to the care planning documentation as a corrective action following the 2018 survey.</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>	FA	<p>Discussions with both the facility and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no notifications required since the previous audit.</p> <p>The service collects incident and accident data and reports aggregated figures monthly to the quality meeting. Incident forms are completed by staff, the resident is reviewed by the RN at the time of event and the form is forwarded to the nurse manager for final sign off. Ten incident forms reviewed identified registered nurse follow-up. There is an incident reporting policy to guide staff in their responsibility around open disclosure. Incident/accident forms include a section to record relatives have been notified. Minutes of the combined quality/staff meetings reflect a discussion of incident statistics and analysis. The caregivers interviewed could discuss the incident reporting process.</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</p>	FA	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files were reviewed (one clinical manager, one registered nurse, one diversional therapist and two caregivers employed since the last audit). All had relevant documentation relating to employment, and current appraisals.</p> <p>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 (sighted in files). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p>

legislation.		There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. There is evidence in the registered nurse files of attendance at the DHB external training. Interviews with two caregivers confirmed participation in the Careerforce training programme. A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed, and a record of completion is maintained and signed. Competency questionnaires were sighted in reviewed files. The clinical manager and a casual registered nurse are interRAI trained.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	<p>Virginia Lodge has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager works four days a week (Monday to Thursday) and is supported by the clinical manager who works Monday to Friday. The registered nurse works four shifts a week, one casual registered nurse works between 2-3 shifts as required per week.</p> <p>They are supported by three caregivers in the morning; 1 x 6.30 am to 3 pm, 1 x 7 am to 11 am and 1 x 7 am to 12 midday, this shift can be extended when acuity of residents is higher.</p> <p>Two caregivers work in the afternoon shift; 1 x 3 pm to 8 pm and 1 x 4 pm to midnight. One caregiver works from midnight to 8 am. The clinical manager and registered nurses share the on-call hours. The clinical manager and the cook (previous caregiver) live on site and are available to help in the event of an emergency.</p> <p>Interviews with the registered nurse, caregivers and residents confirmed that there are sufficient staff to meet care needs.</p> <p>All staff have a current first aid certificate.</p>
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	<p>Virginia Lodge have implemented an electronic medication management system. The supplying pharmacy couriers all medicines in blister packs for regular and 'as required' medications. Medications were checked and signed on arrival from the pharmacy.</p> <p>Registered nurses and senior caregivers are assessed as medication competent to administer medication. Registered nurses have completed syringe driver training. Standing orders were not in use. The medication fridge temperatures have been monitored daily and temperatures were within the acceptable range. Ten medication files were reviewed. Medication reviews were completed by the GP three monthly. PRN medications were prescribed correctly with indications for use. Medications are stored securely in the locked nurses' station. Controlled drug medications are appropriately stored. There were no self-medication residents.</p>

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	<p>There is a functional centrally located kitchen and all food is cooked on site. There is a food services manual in place to guide staff. There are two cooks who have food handling certificates and considerable cooking experience. Food is served from the main kitchen to the dining area adjacent to it. A current food control plan is in place.</p> <p>Special diets are being catered for. The six-week summer and winter menu has been reviewed by a registered dietitian. Residents have had 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 or sooner if required. The two cooks interviewed were aware of changes in resident's nutritional needs and were knowledgeable around the current nutritional requirements of residents.</p> <p>An annual resident satisfaction survey was completed and showed 100% satisfaction with food services for the last two years. Regular audits of the kitchen fridge/freezer temperatures and food temperatures were undertaken and documented. All food is stored appropriately. There is special equipment available for residents if required. Residents and relatives interviewed reported satisfaction with meals using words such as "perfect", "wonderful" and "love the food". Meals are discussed at the resident meetings and feedback is given to kitchen staff.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. The registered nurses and caregivers follow the plan and report progress against the plan each shift. There is documented evidence on the family contact form in each resident file that indicates relatives were notified of any changes to their relative's health. Discussions with relatives confirmed they were notified promptly of any changes to their relative's health. Acute plans of care are used for short-term/acute changes in care. These were in place for wounds and infections in the resident files reviewed.</p> <p>One resident with challenging behaviours had monitoring forms maintained, triggers, behaviours and de-escalation techniques specific to this resident were in place. The previous finding has been addressed.</p> <p>There were five wounds on the day of the audit including a suspected pressure injury/ischaemic wound which was reviewed by the wound specialist on the day of the audit. All wounds had individual wound assessments, plans and evaluations which indicated progression or deterioration of the wounds. Adequate dressing supplies were sighted in treatment rooms.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern.</p> <p>Monitoring forms are used for weight and vital signs, blood sugar levels, pain, challenging behaviour, food and</p>

		fluid charts.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	<p>There is one diversional therapist who works 12 hours a week across Monday to Friday mornings. The diversional therapist has a current first aid certificate. Activities assessments, map of life and care plans were completed, and evaluations were completed six monthly.</p> <p>The monthly programme includes pet therapy, chair exercises, group activities and newspaper reading. The residents fundraise for charities in the community each year, this information and other activity information is displayed on the noticeboard and is discussed at resident meetings. One resident is a keen gardener and grows vegetables in raised beds. Special events include a high tea with fine china, tables are decorated, and entertainment is provided if available. Friends and family of the residents are supportive and bring in pets, lambs, piglets and puppies. There is a rock 'n roll dance group which the residents talked about positively during interviews. Monthly church services and weekly communion are held. One-on-one time with residents occurs which was verified during resident interviews.</p> <p>Van outings occur more often in the summertime and to another facility locally to play group games. The service hires a van/taxi for regular outings.</p> <p>The residents interviewed expressed satisfaction with the current activities programme.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by the clinical manager or registered nurse within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by the clinical manager or registered nurse six monthly, using the interRAI tool or earlier for any health changes for files reviewed. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes or the care plan. The acute plans of care have been reviewed and evaluated
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>Virginia Lodge holds a current building warrant of fitness expiring on 20 June 2020. Preventative and reactive maintenance occurs, and records are maintained. Hot water temperatures are checked randomly and were within ranges. Tradesmen are available if required. Equipment has been tagged and tested.</p> <p>All areas are accessible for residents using mobility aids. There is a large communal lounge area with a side area for residents and relatives to have some privacy if required. Outdoor areas and gardens are well maintained and accessible to residents. The gardens have seating and shade provided by the trees. There is a designated smoking area for residents.</p> <p>The caregivers interviewed stated they have sufficient equipment including mobility aids, wheelchairs and</p>

		pressure injury equipment (if required), to safely deliver the cares as outlined in the residents' care plans. There is a hoist available if required.
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	Virginia Lodge continues to implement their infection surveillance programme. Individual infection alert forms were completed for all infections. Infections were included on a monthly register and a monthly report and graphs were completed by the infection control coordinator (registered nurse). Infection control (IC) issues were discussed at the combined quality and staff meetings. The IC programme is linked with the quality programme. In-service education is provided annually and in toolbox talks when required. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a restraint minimisation and safe practice policy that is applicable to the service. The facility manager is the restraint coordinator. There are currently no residents using restraint or enablers at Virginia Lodge. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint/enabler and challenging behaviour training has been provided annually. Caregivers interviewed could fluently describe the differences between restraint and enablers and procedures around these.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.