

# Lonsdale 2005 Limited - Lonsdale Total Care Centre

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## 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 BSI Group New Zealand Ltd, 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:

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| <b>Legal entity:</b>  | Lonsdale 2005 Limited   |
| <b>Premises audited:</b>  | Lonsdale Total Care Centre  |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| <b>Dates of audit:</b>  | Start date: 23 February 2021      End date: 24 February 2021  |
| <b>Proposed changes to current services (if any):</b>   | None  |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 39  |

# Executive summary of the audit

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## 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   |
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|   | 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  |
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| 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

Lonsdale Total Care Centre cares for up to 50 residents. Lonsdale Total Care Centre provides hospital (medical and geriatric) and dementia level care. On the day of the audit there were 39 residents. The service is managed by a general manager (registered nurse) an administrator and a household manager. The residents and relatives interviewed spoke positively about the standard of care and support provided at Lonsdale Total Care.

This certification audit was conducted against the relevant Health and Disability Services 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, family, management and staff.

The general manager is well qualified and experienced and is supported by a registered nursing team. There are quality systems and processes embedded and being implemented. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care. Staffing has been stable.

This certification audit did not identify any areas for improvement.

A continuous improvement has been awarded for the activity programme and good practice.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | All standards applicable to this service fully attained with some standards exceeded. |
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Lonsdale Total Care Centre practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided. Individual values and beliefs are considered on admission and continuing through the care planning process. There is an open disclosure policy that staff understand. Family/friends are able to visit at any time and ongoing involvement with community activity is supported. Complaints processes are being implemented and complaints and concerns are managed and documented.

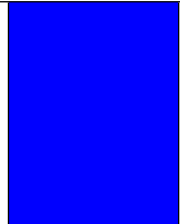
## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |
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The quality and risk management programme includes service philosophy, goals, and a quality planner. Quality activities are conducted, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents'/family meetings have been held. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. An education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees

have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | All standards applicable to this service fully attained with some standards exceeded. |
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The service has assessment processes and resident's needs are assessed prior to entry. There is a well-developed information pack available for residents and families/whānau at entry. Assessments, resident care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools including interRAI assessments and monitoring forms were available and implemented. Care plans were individualised and identified involvement of allied health professionals.

A diversional therapist coordinates and implements an activity programme. She is supported by a group of volunteers. The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting entertainers.

There are medicine management policies in place that meet legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three-monthly.

All meals and baking are prepared and cooked on site. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training. Additional snacks are available 24 hours.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |
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There are documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. Some rooms are shared, and some have an ensuite. There is access to an adequate number of communal toilet/shower facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems and supplies are in place for essential, emergency and security services. There is at least one staff member on duty with a current first aid certificate

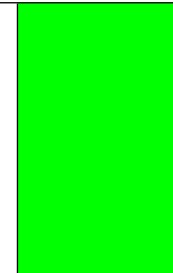
## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. There were thirteen residents with restraint on the day of audit and three residents with and enabler.

## 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 control programme is appropriate for the size and complexity of the service. The infection control coordinators are responsible for coordinating and providing education and training for all staff. The infection control coordinators have attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control team uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections.

## 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 2                           | 48                  | 0  | 0                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 2                           | 99                  | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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>Lonsdale Total Care Centre practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and posters of the Code are displayed in the facility. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with twelve care staff (five healthcare assistants (HCAs) three registered nurses, one gardener, one bedmaker, one cook/kitchen supervisor and one diversional therapist) reflected their understanding of the key principles of the Code.</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</p> | FA                | <p>There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission and sighted in seven of seven resident files reviewed: three hospital, two rest home residents (including one resident under a Mental Health contract) and two dementia care residents. Advance directives for continuing care (where appropriate) were completed and on the resident files. Resuscitation plans were sighted in all files and were signed appropriately. Copies of enduring power of attorney (EPOA) were present in resident files. The EPOA of two of two dementia care resident files reviewed had been activated.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents and where</p> |

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| <p>informed consent.</p>   |           | <p>appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The HCAs and registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>All seven resident's files sampled had signed admission agreements on file.</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>       | <p>FA</p> | <p>Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Advocacy pamphlets are displayed in the entrance to the hospital wing and dementia unit. Healthcare assistants interviewed were aware of the resident's right to advocacy services and how to access the information. Resident advocates are identified on admission. Interviews with residents and relatives confirmed that they are aware of their right to access advocacy.</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> | <p>FA</p> | <p>The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. Community links are established with local community groups. Residents who are able, are supported to come and go from the facility as they please. Visiting arrangements are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Families interviewed stated they are always made to feel most welcome when they visit.</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>                                 | <p>FA</p> | <p>The complaints procedure is provided to residents and families during the resident's entry to the service. Complaints forms are located at the entrance to the facility. The complaints process is linked to advocacy services.</p> <p>A record of complaints received is maintained by the facility manager. One complaint was logged in 2020 and no complaints have been lodged in 2021 (year-to-date). Complaints are being managed in accordance with HDC guidelines. The 2020 complaint logged was successfully dealt with and resolved, the outcome included staff follow-up and feedback to staff meetings.</p> <p>Discussions with residents and families/whānau confirmed that they are provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly. The resident survey results (July 2020) identified that residents and family had a high level of satisfaction</p> |

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|  |    | with the service, the availability of the manager and the complaints process.   |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>  | FA | <p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is available at reception. The general manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the regular resident/family meetings (usually monthly; with breaks due to Covid). Eight residents interviewed (six hospital and two rest home) and four relatives (three hospital and one dementia care) reported that the residents' rights are being upheld by the service. Residents and family members interviewed stated they received sufficient verbal and written information to be able to make informed choices on matters that affect them.</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 are treated with dignity and respect. The residents' personal belongings are used to decorate their rooms. The HCAs interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when care is being provided and do not hold personal discussions in public areas. The double and three person bays have privacy curtains and/or room dividers installed. One resident who resides in a three-person bay said that they felt very secure, and her privacy was always protected.</p> <p>HCAs reported that they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected. Shared toilets include appropriate door locking mechanisms.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive regular education and training on abuse and neglect, which begins during their induction to the service. Spiritual needs are identified, and church services are held.</p> |
| <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>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. A Māori health plan is in place for residents who identify as Māori. Cultural considerations and interventions are identified throughout the care plans (two hospital level care plans reviewed for cultural considerations).</p> <p>Māori consultation is available through a local kaumātua with affiliations to the local Iwi. There is a spiritual advisor and relationship facilitator for Māori residents. Education on cultural awareness begins during the new employee's induction to the service and continues as a regular/annual training topic.</p> <p>One resident who was interviewed and identifies as Māori praised the service and the culturally</p>  |

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|  |    | appropriate care provided to her.   |
| <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>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</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>A staff code of conduct and company house rules are discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with HCAs confirmed their understanding of professional boundaries, including the boundaries of the HCAs role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Interviews with five HCAs could describe how they build a supportive relationship with each resident.</p>   |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>   | CI | <p>The CEO and management team are committed to providing services of a high standard, based on the service philosophy of care. The service has implemented policies and procedures that are developed and reviewed by key people within the organisation, the policies have been written to be clear and easily understood.</p> <p>The service has fostered positive relationships with the families of the residents and the wider community, and this was observed on the days of audit. The manager and the staff stated a sense of pride when describing how they have a reputation for being able to work with residents that other facilities find too challenging and are able to provide optimum quality of life for each of the residents.</p> <p>Residents and family/whānau interviewed reported that they are satisfied or very satisfied with the services received. This was also confirmed in the July 2020 resident/family satisfaction survey. Since their last certification the service has transitioned to electronic records. The service has implemented advanced care plans.</p> <p>The service receives support from the district health board (DHB).</p> <p>A van is available for regular outings. A quality initiative has been implemented around supporting</p> |

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|   |    | residents to be more independent.   |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>An open disclosure policy describes ways that information is provided to residents and families and the management team promotes this. The information pack contains a range of information regarding the scope of service provided to the resident and their family on entry and any items they have to pay for that is not covered by the agreement. Residents receive a regular newsletter (The Goss) that keeps them informed on all matters that affect them, community news and facility renovations.</p> <p>The information pack is available in large print and advised that this can be read to residents. Interpreter services are available as required. Relatives interviewed, stated that they are informed when their family member's health status changes. Discussions with HCAs and RNs identified their knowledge around open disclosure. There are resident meetings regularly that provide the opportunity for feedback on the services.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Ten accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. Staff and family are used in the first instance.</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> | FA | <p>Lonsdale Total Care Centre is a 50-bed facility that provides rest home, hospital/medical and dementia level care. Occupancy on the day of audit was 39 residents. There were ten rest home residents including two residents funded through mental health services and one younger person disabled (YPD), twenty-two hospital residents including one YPD resident and one resident on respite care. There were seven residents in the dementia unit. There are 10 dual purpose beds. All other residents were under the Age-Related Residential Care (ARRC) contract.</p> <p>A general manager manages both Lonsdale Total Care and Riverside rest home (5 kms down the road). The general manager (GM) is based at Lonsdale but visits Riverside daily. The manager has been in the role since October 2014 and with the service for over five years and is a registered nurse. The general manager also oversees clinical management. The general manager is supported by a household manager, office manager and lead RN. The household manager oversees the non-clinical services and has been in the position for over 10 years. The general manager has maintained at least eight hours of professional development annually, attending relevant courses and forums provided at the DHB.</p> <p>The CEO (owner) meets monthly with the general manager, the general manager of the education</p> |

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|   |    | <p>centre, household manager and office manager.</p> <p>There is an overall business/strategic plan which includes the sister site (Riverside) and there is a comprehensive quality and risk management programme in place for the current year. The business/strategic plan and quality and risk management programme for 2020 has been reviewed. The 2021 plan includes the reduction of polypharmacy, infection control, pandemic management: including management of staff anxiety and environmental refurbishment. The organisation has a philosophy of care, which includes a mission statement.</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> | FA | <p>A team are responsible for acting management during the temporary absence of the general manager. The team includes: the household manager and office manager for non-clinical management and the lead RN for clinical leadership.</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>The quality and risk management programme is designed to monitor contractual and standards compliance. There are policies to guide the facility to implement the quality management programme including (but not limited to): quality assurance and risk management programme, management responsibilities, health and safety and infection control responsibilities and internal audit schedule. There is an implemented and up-to-date schedule of policies reviews and updates.</p> <p>Quality information is collated and presented as a power point presentation (the clinical review) at the monthly staff meetings and also monthly management meetings. The general manager has designed the clinical review presentation as an information sharing tool and also a learning and discussion tool. Staff interviewed stated they are well informed and receive quality and risk management information such as accident/incident statistics and infection control statistics. A comprehensive internal audit has been implemented. Data is collected around operational and clinical areas of the business including accidents, incidents, complaints, infections, restraint use, and feedback on the customer experience.</p> <p>The HCAs interviewed spoke highly of the management team and stated they are asked for suggestions and feedback on quality initiatives. There were a reduced number of meetings Covid-19 alert levels in 2020, however a series of emails and letters to staff, residents and families ensured they were all updated around Covid-19. Resident/relative meetings have been held quarterly during 2020.</p> |

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|   |    | <p>There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The household manager is the designated health and safety person. Issues and concerns are addressed in the monthly staff and monthly management meetings.</p> <p>Falls prevention strategies are implemented for individual residents, and staff receive training to support falls prevention.</p> <p>Satisfaction surveys are completed annually. The survey results are collated to identify if there are any areas for improvement. The resident/relative satisfaction survey for 2020 identified that residents and family are very satisfied with all aspects of the service delivery and the results were posted in the monthly residents/relatives (The Goss) newsletter.</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>There is an accident/incident policy, which is part of the risk management plan. Monthly data collection of accident/incidents is completed. When an incident occurs, the staff member discovering the incident completes the accident/incident form. The incident/accident is documented in the progress notes. The RN on duty completes a clinical assessment and identifies preventative and corrective actions. All incidents/accidents are signed off by the general manager, who conducts a further investigation if required. Sixteen incident forms sampled evidenced detailed investigations and corrective action plans following incidents, including neurological observations for three of the resident related incidents.</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>   | FA | <p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience, and veracity. A copy of practising certificates is kept. Eight staff files were reviewed (three registered nurses, one diversional therapist, two kitchen staff and two healthcare assistants) and there was evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There is a comprehensive training plan in place. The plan includes online training, face to face training, and additional training provided as part of the monthly staff meetings. Staff meeting training is as a response to quality data and any issues raised during the month. The registered nurses are able to attend external training, including sessions provided by the local DHB. Four of the seven registered nurses have completed interRAI training with the clinical coordinator currently enrolled in the programme.</p> |

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|   |    | There are seven healthcare assistants who work in the dementia unit with six having completed dementia unit standards as required in the contract. There is one casual staff who relieves in the unit who has not completed dementia training; however they always work with a senior HCA (who has completed the unit standards).   |
| <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>Policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. Activities are provided seven days a week. Staff working on the days of the audit were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers. On call is provided by the management team. The service has compared its staffing with national averages and the comparison document that Lonsdale compared favourably.</p> <p>There is one RN rostered for the dementia unit and rest home unit during the day (across seven days). There is one RN in the hospital in the morning, one RN in the hospital in the afternoon and one RN in the hospital overnight.</p> <p>Healthcare assistant staffing:</p> <p>Hospital wing: (14 residents at hospital level and 3 at rest home). AM two full shifts, PM one full shift and one short shift.</p> <p>Rest home: (8 residents at hospital level and 7 at rest home). AM one full shift and one short shift, PM one full shift and one short shift.</p> <p>There is one HCA across the rest home and hospital at night.</p> <p>There is a 'bedmaker' employed 9 am to 1 pm seven days a week.</p> <p>In the dementia unit, (seven residents) there are two HCAs in the morning, one full shift and one short shift in the afternoon and one at night.</p> <p>Residents and relatives interviewed confirmed that there are sufficient staff on site at all times and staff are approachable and, in their opinion, competent, respectful and friendly.</p> <p>HCAs interviewed stated that there was sufficient staff, and any absentees get replaced within the team.</p> |
| Standard 1.2.9: Consumer Information Management   | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the  |



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| <p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>  |    | <p>public. Resident files are protected from unauthorised access by being held in a secure office in all areas. Care plans and notes are legible, signed and dated by the RN or HCA. All progress notes are entered on the electronic resident database.</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' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs including information on the dementia care service is provided for families and residents prior to or on admission. Prior to entry, all potential residents have a needs assessment, completed by the needs assessment and coordination service to assess suitability for entry to the service.</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>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</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>              | FA | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses and HCAs who administer medications have been assessed for competency on an annual basis. Registered nurses complete syringe driver training. Education around safe medication administration has been provided. Medications are checked on delivery by the RNs. There were no standing orders at time of audit. There was one resident self-medicating an inhaler on the day of audit. There was safe storage, and the resident was assessed as competent to self-medicate. Medications are stored safely. Fridge and room temperatures are monitored, and action undertaken as appropriate. Two of the storage areas are about to be amalgamated into one with an air conditioning unit installed. All eye drops were dated on opening.</p> <p>All fifteen medication charts reviewed (six hospital, four rest home and five dementia care) on the electronic medication system, met legislative prescribing requirements. The GP has reviewed the medication charts three-monthly.</p> |

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| <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>                                  | <p>FA</p> | <p>All food is prepared on site. There is a summer and winter four-week rotating menu approved by the dietitian. The verified food control plan expires February 2021. There are alternative meal options available and resident likes/dislikes and preferences are known and accommodated. Special diets include modified for diabetics and pureed meals as assessed for residents by the RN. The kitchen supervisor receives a dietary profile for each resident. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required. There is a kitchen supervisor and six staff: three cooks and three kitchenhands, who roster duties. There are two on in the morning and one in the afternoon. At Lonsdale, meals are delivered in a bain marie to the rest home and hospital dining rooms. Meals for the dementia care residents are plated and delivered in a hot box to the dining area. There are nutritious snacks available 24 hours in the dementia unit kitchenette.</p> <p>All food services staff have completed food safety units and refreshers. End-cooked temperatures are taken and recorded daily. Fridge, freezer and dishwasher temperatures are monitored daily. All goods in the pantry were date labelled. All perishable foods in fridges were date labelled. Chemicals are stored safely. Staff were observed wearing personal protective clothing. Cleaning schedules are maintained.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <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>FA</p> | <p>The admission policy describes the declined entry to services process. Lonsdale records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whānau back to the referral agency.</p>   |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>   | <p>FA</p> | <p>The RN completes an initial assessment on admission including risk assessment tools. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summary were in place for all long-term resident files sampled. The long-term care plans in place reflected the outcome of the assessments.</p>  |

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| <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>Resident care plans reviewed were resident focused and individualised. Support needs were included in the care plans for all long-term resident files reviewed. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration and evidence of allied health care professionals involved in the care of the resident such as the physiotherapist, hospice service, tissue viability nurse and mental health services.</p> <p>Short-term care plans were in place for short-term needs. Short-term care plans had been reviewed regularly and either resolved or transferred to the long-term care plan if an ongoing problem.</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>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to): accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds and skin tears. There were three pressure injuries in the hospital on the day of audit (a grade 1, grade 2 and a grade 3). There was a range of equipment readily available to minimise pressure injury.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health.</p> <p>Monitoring occurs for weight, vital signs, blood glucose, pain, challenging behaviour, wounds, restraint and continence. Registered nurses review the monitoring charts and report identified concerns to the GP or nurse specialist.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements</p>                                  | <p>CI</p> | <p>The service has a qualified diversional therapist (DT) who is supported by many volunteers. The activity team provide an integrated rest home, hospital and dementia activity plan Monday to Friday. There are organised activities during the week and other activities initiated by the HCAs in the weekends. Activities are held in several locations within the facility. The variety of activities meets the abilities of all residents. Volunteers spend one-on-one time with residents along with playing an integral role in the activity programme. Entertainers attend the home regularly and there are regular outings and drives for</p>   |

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| <p>are appropriate to their needs, age, culture, and the setting of the service.</p>   |           | <p>all residents. Residents are supported to attend religious services within and outside the facility. Residents are encouraged to maintain links within the community including schools. The service provides transport for residents to attend their community groups. There are a variety of activities catering for individual resident needs including special garden projects and adapted games (circle bowls). Special events and festivities are celebrated, and families are invited to attend.</p> <p>One-on-one time or small group activities are carried out with the dementia residents (observed on the day of audit). Healthcare assistants in the dementia unit facilitate small group or individual activities at other times. There are adequate resources available.</p> <p>An activity assessment and plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed six-monthly.</p> <p>Residents and families have the opportunity to feedback on the activity programme through meetings and surveys.</p> |
| <p>Standard 1.3.8: Evaluation<br/>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | <p>FA</p> | <p>Initial care plans reviewed were evaluated by the RN within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. The written evaluation documents the resident's progress against identified goals. The GP reviews the residents at least three-monthly or earlier if required. The multidisciplinary team includes the general manager (clinical), DT, registered nurse, resident/relative and any allied health professional involved in the care of the resident. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Changes are made to care plans.</p>   |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br/>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> | <p>FA</p> | <p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>  |
| <p>Standard 1.4.1: Management Of Waste And Hazardous</p>   | <p>FA</p> | <p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety data sheets are readily accessible for staff. Chemical</p>  |

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| <p><b>Substances</b></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>                      |           | <p>bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the days of audit. The chemical provider monitors the use of chemicals and provides chemical safety for all relevant staff.</p>   |
| <p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>  | <p>FA</p> | <p>Lonsdale Hospital and Rest home has a current building warrant of fitness that expires 31 March 2021.</p> <p>Lonsdale is a large, spacious single storey building with safe internal access between the bedrooms and communal areas of the rest home and hospital.</p> <p>Hallways are sufficiently wide enough to allow residents to mobilise safely with the aid of walking frames and other mobility aids.</p> <p>There is a maintenance person for 32 hours per week and a gardener for eight hours per week. There are casual staff who also come to assist. There is a maintenance logbook for repairs and maintenance requests (electronic). Minor repairs are addressed and signed off. Essential contractors are available 24 hours. There is a monthly planned maintenance plan that includes environmental and resident equipment maintenance. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated annually. Planned maintenance includes call bell and hot water temperature monitoring monthly.</p> <p>There is safe access to outdoor areas. Seating and shade are provided.</p> <p>The dementia care unit has exit and entry points to the safe outdoor walking pathway and garden areas which provide seating and shade.</p> <p>The RNs and HCAs (interviewed) stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> |
| <p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements</p> | <p>FA</p> | <p>Lonsdale toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are sufficient numbers of communal toilet/showers in each unit. The hospital unit has a large shower room that can accommodate a shower trolley. Three rooms have an ensuite and three further rooms share an ensuite. Privacy curtains and engaged/vacant signs ensure resident privacy.</p>   |

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| or receiving assistance with personal hygiene requirements.   |    |   |
| <p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>  | FA | <p>At Lonsdale, six of the dual-purpose rooms are double rooms and three are single. In the hospital unit, there are two bedrooms (triple beds), three double rooms and six single rooms. In the Malthus unit there are two double bedrooms and four single. There is one double room in the dementia unit. All other rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms.</p> <p>Residents and families are encouraged to personalise their rooms. This was evident at both sites on audit day.</p>  |
| <p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>The main rest home has an open plan lounge and dining area kitchen. The hospital has a large open plan lounge and dining room. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. The Malthus unit has another dining room and lounge. There are seating areas within the facility and a family lounge with tea making facilities. Activities occur throughout the facility. Residents are able to move freely, and furniture is well arranged to facilitate this.</p> <p>In the dementia care unit there is adequate space to allow maximum freedom of movement while promoting safety for those that wander. The dementia unit has a quiet lounge and a separate dining area. There is a smaller activity lounge and seating alcoves within the unit.</p> |
| <p><b>Standard 1.4.6: Cleaning And Laundry Services</b></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>                     | FA | <p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There is an external laundry building with defined clean/dirty flow. There is a dedicated laundry person. All personal clothing and linen are laundered on site. The washing machine has an outbreak cycle. All equipment has a six-monthly service.</p> <p>The contracted chemical supplier monitors the effectiveness of the cleaning and laundry processes. The cleaners' trolleys are well equipped and are kept in designated locked areas when not in use.</p>  |
| <p><b>Standard 1.4.7: Essential, Emergency, And Security Systems</b></p> <p>Consumers receive an appropriate and timely response</p>  | FA | <p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing.</p> <p>Civil defence supplies are readily available on site including a 1,000L water tank, other bottled water store (changed six-monthly), adequate food storage, bottled gas cooking appliances, a barbeque and an</p>  |

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| <p>during emergency and security situations.</p>  |           | <p>emergency generator.</p> <p>There are six-monthly fire drills. Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.</p> <p>Residents' rooms, communal bathrooms and living areas all have a wireless call bell system that generates calls on staff carrying pagers. Security policies and procedures are documented and implemented by staff. The buildings are secure at night with doorbell access.</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>Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. There are sufficient doors and opening windows for ventilation. All bedrooms have good sized windows which allow plenty of natural light.</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 infection control programme is appropriate for the size and complexity of the service, policies developed by Bug Control are the main tools used for IC guidance. There is an infection control responsibility policy that includes responsibilities for the infection control team. The infection control coordinator is an RN, who has undertaken the role for two years. The infection control coordinator is part of a team that includes the household manager and general manager (also an RN).</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the two facilities.</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 infection control coordinator has attended external education annually. The service is affiliated with an external infection control organisation for any advice or updates for policies.</p> <p>The infection control team meet monthly and provide reports at the clinical review meetings. The facility has access to an infection control nurse specialist at the DHB, external infection control consultant, public health, laboratory, GPs and DHB wound nurse.</p> <p>A Covid strategy and pandemic plan was available to staff on site with education and associated resources relating to hand hygiene, PPE and donning/doffing procedures. The service maintains a large supply of PPE (due to its rural location).</p> |

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|  |    | The service implemented cohort nursing during the lockdown and closed all units to each other to prevent residents moving between units.  |
| <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 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> | FA | There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. The infection control policies (last reviewed April 2020) links to other documentation and cross reference where appropriate.   |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>  | FA | <p>The infection control coordinators are responsible for coordinating and providing education and training to staff. The orientation package includes specific training around hand washing competencies and standard precautions. Ongoing training occurs annually as part of the annual training programme. Staff are required to complete infection control questionnaires following education.</p> <p>Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</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>  | FA | <p>Infection surveillance is an integral part of the infection control programme. Surveillance of all infections is entered into a monthly infection summary. Infection control information is collected and collated monthly and presented to the monthly clinical review meetings. As with all quality information it is presented using a PowerPoint and used to promote discussion and provide education.</p> <p>There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> |
| Standard 2.1.1: Restraint  | FA | There are policies around restraints and enablers last reviewed June 2020. The service currently has  |



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| <p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>  |    | <p>13 residents assessed as requiring the use of restraint (bed rails and lap belt) including two residents requiring lap belt restraint in the dementia unit. While restraint was being used for two residents in the dementia unit, one resident was having a bedside positioned when in bed and a lap belt was being used for another resident when in a chair. Both restraints had recently been commenced and were being utilised whilst the two residents were reassessed for higher levels of care. Neither were in use the week of audit.</p> <p>There is a restraint coordinator who reports to the RN meetings and general manager. There is documented evidence of consultation with the resident and family/whānau regarding the use of restraint. Residents voluntarily request and consent to enabler use. There were three enablers in use on the day of audit.</p> <p>Staff receive training around restraint minimisation on orientation and as part of the annual education programme.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | FA | <p>A restraint approval process and a job description for the restraint coordinator/RN are in place. The resident/family/whānau as appropriate are consulted prior to the use of restraint and receive written information on restraint use. The GP is involved in the approval process. Three of three care plans reviewed for residents on restraint identified the use of restraint, a formal assessment process and evaluations. Healthcare assistants interviewed were knowledgeable on the use of restraint and approval processes.</p>  |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>  | FA | <p>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. Two hospital level residents' files and one dementia level where restraint was being used were selected for review. Each file included a restraint assessment completed by a RN or restraint coordinator. The consent forms were signed by the resident's family and GP. Restraint use is linked to the resident's care plan including the risks identified with the use of restraint.</p>   |

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| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>  | <p>FA</p> | <p>A restraint register is in place. The register identifies the residents that are using a restraint and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. The electronic system for resident records including the progress notes, includes a declaration for the monitoring of restraints and cares delivered throughout the restraint use.</p> |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>   | <p>FA</p> | <p>Restraint use is reviewed monthly by the restraint coordinator and reported to the RN meeting. Restraint use is reviewed six-monthly as part of the care plan review. The review process includes discussing whether continued use of restraint is indicated.</p>  |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | <p>FA</p> | <p>The restraint programme, including reviewing policies and procedures and staff education is evaluated annually by the restraint coordinator and general manager as part of the internal review. Restraint audits identify opportunities for improvement. The service is reviewing the number of restraints and looking at ways to minimise.</p>  |

## Specific results for criterion where corrective actions are required

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

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

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

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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome   | Attainment Rating | Audit Evidence  | Audit Finding  |
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| <p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p> | CI                | <p>Lonsdale has a policy of accepting a wide range of residents for admission. The manager and RNs assesses each new resident to ensure the service can safely and effectively support regardless of the resident's history. This has led to the service providing support for a diverse population who sometimes don't fit the norms of the DHB contract. A wing of Lonsdale has been adapted to provide more individualized support for a small group of residents who need a subtly different style of care than aged-related residents.</p> | <p>The team at Lonsdale identified a group of residents who had the potential to have more independence and live a less institutionalised life. A small wing in Lonsdale (previously set up for isolation as part of the service covid response) was identified as an area that was able to accommodate residents who would benefit from a more “ supported living’ environment whilst still benefitting from the rest home or hospital level care support.</p> <p>Improvements were made to the living environment – among these a bathroom was revamped, and cosmetic improvements made to the bedroom and living areas. Replacement floor coverings are planned for 2021-22. A computer station with broadband internet access was provided. A CCTV monitoring system was installed to manage the safety risk posed by distance from the nursing station.</p> |

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|   |    |   | <p>The management team worked with a group of residents to ensure they were willing to be involved in the venture and the team considered safety needs for each individual resident prior to supporting them live and function in that environment.</p> <p>A supported flatting environment has developed within this unit of the facility. Each of the residents is happier in this environment. One resident had a habit of pulling her bed across the doorway to prevent nurses entering overnight. This has completely stopped.</p> <p>Another resident's interaction with others and her general mental state and presentation have improved dramatically. Two residents reported they are very happy living in the wing and feel safe.</p>  |
| <p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | CI | <p>The standard requires that activities are required that are appropriate to the needs, age, culture and setting of the service. Particularly during Covid-19 lockdown a programme was delivered that significantly exceeds contract requirements.</p> <p>The issue was identified by the DT when levels were first announced, and planning began to manage safety and visiting requirements. The risk to the resident's psychological well-being if isolated from the community for a period of time given the high level of engagement we enjoy with volunteers and integration with the wider community.</p> <p>Issue – isolation, loneliness, too much free time to develop negative mood. This was an issue for our cognitively intact residents who require the mental stimulation. The risk of brooding over the excessive amount of negative news particularly affecting their demographic (nationally and internationally) was significant.</p> | <p>An evening activities programme ran for the time that the residents were in lockdown (seven to eight weeks). The programme operated four nights per week (Monday, Wednesday, Thursday and Saturday night) and consisted of activities that were different to or an extension of the regular programme. Participation rates were high and enthusiastic. Photographs and anecdotes were shared by email with family and video visiting was promoted to maintain connections.</p> <p>As a result of this programme the residents bonded as a group and the negative outcomes of lockdown were avoided. Staff gravitated to the activities improving the cohesion between staff and residents.</p> <p>Photographic evidence was viewed on audit. In 2019 the facility scored 93% on satisfaction survey of activities. In 2020 in spite of all the restrictions of Covid-19, the facility scored 98% on satisfaction survey of activities.</p> |

End of the report.