# Lakewood Rest Home Limited - Lakewood Rest Home

## 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 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Lakewood Rest Home Limited

**Premises audited:** Lakewood Rest Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 26 July 2021 End date: 27 July 2021

**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:** 35

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Lakewood rest home is certified to provide dementia level care for up to 36 residents. On the day of audit there were 35 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability service 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 of residents and interviews with relatives, staff, the general practitioner, and management.

The manager (non-clinical) has owned Lakewood for the past 16 years and been in the manager role for two years. She is supported in the role by a service supervisor who is an experienced healthcare assistant and an experienced clinical nurse manager who has been in the role for since 2017.

Relatives and the GP interviewed were very complimentary of the services and care residents receive.

The service has addressed three of five previous audit shortfalls around informed consent, care plan documentation and implementation. Improvements continue to be required around implementation of the quality programme and staff training.

This surveillance audit identified a further area for improvement around evaluation of short-term care plans.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained. Policies are implemented to support residents’ rights, communication and complaints.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Lakewood rest home have policies and procedures in place which support residents that require dementia level care. A documented quality and risk management programme is implemented. There is a current business plan that includes specific goals for 2021.

Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope and strategic direction.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Staff receive ongoing training and there is a training plan developed and commenced for 2021. Rosters and interviews indicated sufficient staff that are appropriately skilled with flexibility of staffing around clients’ needs.

An annual relative satisfaction survey is completed. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through.

## Continuum of service delivery

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

The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed on the electronic system demonstrated service integration. The general practitioner reviews the residents at least three-monthly. Allied health professionals are involved in the care of residents as required.

Medication policies reflective of legislative requirements and guidelines were documented. The registered nurses and healthcare assistants are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The diversional therapist provides and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. 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. |

Lakewood rest home has a current building warrant of fitness and reactive and preventative maintenance occurs. All equipment is tagged and tested annually. There is easy access to all internal and external communal areas with seating and shade provided in the garden areas. The dementia area is secure.

## 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. |

Lakewood rest home has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were no residents using restraint or enablers. Staff receive training in restraint minimisation and challenging behaviour management

## 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. |

Lakewood rest home continues to implement their infection surveillance programme. Infection control issues are discussed at the quality/staff meetings. The infection control programme is linked with the quality programme.

Covid-19 was well documented, logs were maintained, and contact tracing methods continue in line with current guidelines. There were adequate supplies of personal protective equipment sighted. There has been one outbreak since the previous audit which were well managed.

## 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 | 15 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 43 | 0 | 1 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and consent for outings. Permissions granted are also included the admission agreements. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. All files evidenced that family members are not making ` not for resuscitation` decisions. This is an improvement from the previous audit and the criteria has been met. Copies of the residents’ advance directive where applicable, are on file. Two long-term resident files and one respite resident had copies of the activated EPOA on file, two residents` welfare guardianship were processed through the court (for reappointment). |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure is provided to residents and relatives on entry to the service. The service maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. Discussions with relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. There were two complaints made in 2020 year to date and was reviewed with evidence of appropriate follow-up actions taken. Documentation including follow-up conversations, resolution and demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). During interview with the clinical nurse manager and seven staff (four healthcare assistants, one cook, one kitchen hand, one diversional therapist) all reported their understanding of the complaints process. Staff confirmed that complaints are discussed with them, and they notify the RN and/or the management if any residents or relatives want to make a complaint.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The managers and registered nurses confirmed family are kept informed. The three relatives available for interview during the audit stated they are notified promptly of any incidents/accidents. Families receive newsletters that keep them informed on facility matters and events. Incident and accident forms sampled, and files reviewed evidenced that family are notified following adverse events or when there is a change in resident’s condition. Resident/family meetings encourage open discussion around the services provided (meeting minutes sighted). There is access to an interpreter service as required. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lakewood rest home is owned and managed by a non-clinical owner/manager. The home provides dementia level care for up to 36 residents. On the day of audit there were 35 residents in total, including one resident on respite care. The manager has owned Lakewood for the past 16 years and been in the manager`s role for 2 years. She is supported in the role by a service supervisor who is an experienced healthcare assistant (in the role for two and a half years) and an experienced registered nurse (clinical nurse manager) who has been in the role since 2017. Another registered nurses and enrolled nurse complete the clinical team.A vision, mission statement and objectives are in place. There is a documented business plan, nursing objectives and risk plan documented, which were reviewed February 2021. The quality process has been developed by an external consultant and personalised to the service. The manager, service supervisor and clinical nurse manager has maintained over eight hours annually of professional development activities related to their roles managing.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | A quality and risk management programme is documented. Interviews with the managers and staff reflected their understanding of the quality and risk management systems.There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. Monthly staff/quality meetings have a set agenda that covers all aspects of the service quality meetings. Additional agenda items are documented as discussed as needed, including staff issues, feedback and as ad hoc training as needed. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. Each month the clinical nurse manager reviews and collates the quality and risk data as well as infection control. A report is documented, and an action plan developed. This report and action plan are reported to staff meetings, action plans are followed up and signed off. The shortfall related to this issue has now been addressed.Internal audits have been completed for 2020 as per the internal audit schedule and on track for 2021 this includes medication management, informed consent, challenging behaviour and a relative survey. Any area of non-compliance includes the implementation of a corrective action plan with sign-off by the clinical nurse manager and manager when it is completed. Re-audits are completed where required. The shortfall from the previous audit related to the implementation of the audit schedule. This has been addressed; however the audit outcomes have not been discussed at monthly meetings.An annual satisfaction survey has been completed with relatives in 2019 and 2020, however the data has not been collated, analysed or discussed at staff meetings. The next relative survey is scheduled for August 2021. A health and safety system is in place. There are health and safety policies and procedures documented. The service has four monthly health and safety meetings separately from the staff/quality meeting. Hazard identification forms and a hazard register are dated, signed and have been reviewed as part of the staff/quality meetings.The health and safety representative has allocated time to complete health and safety responsibilities including hazard reviews and checks, fire drills, staff health and safety inductions and training. The hazard register is available to all staff. A health and safety noticeboard (sighted) keeps staff informed on health and safety matters and meetings.Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Interventions include intentional rounding, sensor mats, clear transfer and mobilisation guides and involving the physiotherapist to complete mobility assessments for residents identified at risk of falls.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | The service collects incident and accident data on forms and enters them into a register. Twelve incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process. The service supervisor and clinical nurse manager collects incident forms, investigates and reviews and implements corrective actions as required. There was evidence of comprehensive follow-up after an unwitnessed fall with GP involvement in a timely manner. Nursing care included a short-term care plan for a skin-tear, neurological observations and additional supervision for the resident (intentional rounding).There have been no section 31 notifications completed since the last audit and one confirmed Norovirus outbreak reported to Public Health in April 2021.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Moderate | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (clinical nurse manager, service supervisor, the DT, healthcare assistant and kitchen hand), evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. Practising certificates is maintained on file and current.The service has an orientation programme in place that provides new staff with relevant information for safe work practice. New staff are buddied for a period of time and during this period they do not carry a clinical load. Healthcare assistants reported that they feel very supported in their role.There is a monthly education and training schedule being implemented. Significant, informal opportunistic education is provided during staff meetings and has included communication, toileting, fingernail care, and chemical safety as examples. The formal training and informal training have covered all compulsory subjects (including abuse and neglect, wound care, medication, challenging behaviour, restraint, ageing process and communication) since the last audit. This shortfall identified at the previous audit has been addressed. The content of the training sessions was not documented, this is a continued shortfall. All staff have completed the mandatory annual training, competencies and education. 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 healthcare assistants confirm participation in the New Zealand Qualification Authority (NZQA) through the Careerforce training programme. There are 17 health care assistants working across all shifts. Fourteen health care assistants and one DT have completed the required dementia training. Two newly appointed health care assistants are yet to be enrolled and one health care assistant are working towards the completion of the qualification and have been employed for less than 18 monthsThere are three healthcare assistants with level 4 NZQA, and 12 with level 3 NZQA. A further two healthcare assistants are enrolled to complete level 3 training. Eleven HCAs, the service supervisor, the clinical nurse manager and enrolled nurse hold a first aid certificates including all rostered staff on afternoon and night shifts. 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 nurse manager is 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 | The staffing levels meet contractual requirements. Interviews with the staff and relatives confirmed staffing overall was satisfactory. The staffing includes the owner/manager Monday to Friday and the non-clinical supervisor, Monday to Friday. A clinical nurse manager (registered nurse) and registered nurse share the am shifts Monday- Sundays. The fulltime enrolled nurse (commenced employment on the day of the audit) will work afternoon and night shifts where required.For all AM and PM shifts there are five HCAs, three are designated for resident care (2x 7am-3.30pm and 1x 12pm -8.30pm), and two to assist with housekeeping (7am-3.30pm) and laundry (7am-2pm). There is also an additional kitchenhand for tea assist for the afternoon shift. Afternoons are covered by four HCAs (2x 3.30pm-midnight, 1x 4pm -9pm and 1x 5pm-10pm).There is an HCA and RN for the night shift (Monday- Friday) and two HCAs over weekend nights. RNs and HCAs interviewed stated that resident care is a first priority for all staff, with the staff designated for housekeeping and laundry assisting with resident care. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies available for safe medicine management that meet legislative requirements. Registered nurses and senior HCAs who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided annually (link 1.2.7.5). Staff were observed to be safely administering medications including signing for medications on the electronic system at the time of administration. The registered nurse and healthcare assistants interviewed could describe their role regarding medication administration.The service currently uses robotic rolls for regular medication and blister packs for ‘as required’ medications. All medications are checked by an RN on delivery against the medication chart and date of checking entered into the electronic medication system. Any discrepancies are fed back to the supplying pharmacy. All medications were stored appropriately and within the expiry dates. Lakewood is a secure dementia unit and there are no self-medicating residents. The service does not use standing orders. The medication fridge temperature is recorded daily and is maintained within an acceptable range. Medication room air temperatures are recorded daily. Ten charts were reviewed. The electronic medication charts reviewed identified that the GP had reviewed all resident’s medication three monthly and all allergies were noted. All resident charts included photo identification. The effectiveness of ‘as required’ medications was recorded on the electronic medication system |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All food is prepared and cooked on site at Lakewood rest home. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. The Monday to Friday cook and weekend cook is supported by morning and afternoon kitchenhands. There are four weekly rotating summer and winter menus which have been reviewed by the dietitian June 2021. Meals are cooked and held in a bain-marie until plated and served to residents in the adjacent dining room. The cook receives notification of any resident dietary changes and requirements. Dietary needs shown in the care plan match information found in the kitchen and is consistent with residents’ immediate needs. Dislikes and food allergies are known and accommodated. Soft, pureed meals are provided as assessed by the RN or dietitian. Resident weights are monitored monthly, and the cook is notified of any residents with weight loss. Drinks and snacks are available over 24/7 for residents such as sandwiches, fruit, jellies, puddings, yoghurts, ice-cream and sweet treats. The service has a food control plan verified and valid until April 2022. Fridge and freezer temperatures are checked and recorded daily. End-cooked food temperatures are documented daily. Inward goods and chilled goods are checked for acceptable temperatures and recorded. All foods were stored correctly, and date labelled. A cleaning schedule is maintained. The dishwasher is serviced monthly by the chemical provider. Feedback on the meals is through observation of residents at mealtimes and direct communication with residents as able. Four monthly family meetings and surveys provide an opportunity for relative feedback on the food service. Families interviewed stated they were satisfied with the food service. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The resident files reviewed were resident focused, integrated, and promoted continuity of service delivery, and all care plans documented current supports and guidelines for staff. The shortfalls identified at the previous audit related to diabetes management, dietary requirements and restraint management has been addressed.All resident files included an initial care plan developed in consultation with the family, allied health professionals’ input and information from discharge summaries. All files had a long-term care plan in place that reflected the outcomes of interRAI and risk assessments. Behaviour management plans included potential behaviours, triggers and interventions/de-escalation techniques including activities to re-direct the resident from challenging behaviours. Short-term care plans were in place for acute and short-term conditions, short term care plans related to infections have not been evaluated on a regular basis and signed as resolved (link 1.3.8.3). Where conditions were ongoing these were transferred to the long-term care plan as an ongoing problem. Family members interviewed confirmed they had been involved in the care planning development and review process. The files included allied health involvement in the care of the residents including GP, dietitian, older person mental health team, pharmacist and podiatrist.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses and healthcare assistants follow the care plan and report progress against the care plan each shift at handover. Interviews with registered nurses and healthcare assistants demonstrated an understanding of the individualised needs of residents. When a resident condition changes the RN accesses GP or specialist nursing advice or visit. Family is notified of any changes to the resident’s health including medication reviews, GP visits, accidents/incidents, infections and behaviours of concern. Short-term care plans document interventions required for short-term problems and have been implemented (link1.3.8.3). Two files of the five reviewed show that assessed falls risk rating match what is shown on the care plan. There was a current dietary profile and interventions in place for one dementia care resident with unintentional weight loss and neurological observations completed for three of three unwitnessed falls. Adequate dressing and medical supplies were sighted in the treatment room on the day of audit and staff interviewed reported they had access to sufficient dressings. There were two wounds on the day of audit including a vascular ulcer and skin tear. Wound care plans in place identified an initial wound assessment with size of wound and ongoing monitoring of the size of wounds. This is an improvement on the previous audit. The GP reviewed wounds as per medical notes. The vascular service had been involved for the resident with a vascular ulcer. The wound nurse at Nurse Maude is available for any advice or support regarding wound care. Sufficient continence products are available and resident files include a continence assessment. Specialist continence advice is available as needed and this could be described. There was evidence of monitoring charts in use (but not limited to), 15 minutes checks, food and fluid charts, blood glucose level monitoring, bowel monitoring, neurological observations, weight monitoring, pain monitoring, wound and behaviour charts. The shortfall identified at the previous audit related to monitoring charts has been addressed.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 | The service employs a qualified diversional therapist (DT) five days a week, from 9 am to 5 pm. The activity programme is provided across the seven-day week with HCAs incorporating activities as part of their role over the 24 hours. There are plenty of resources available. Activities planned for the day are displayed on the noticeboard. The programme reflects the resident’s interests and abilities, and they have choice in their level of participation. Activities include (but are not limited to) ball/balloon exercises, tenpin bowls, skittles, group walks, reminiscing, painting, arts and crafts, board games, happy hours, singalongs and gardening. One-to-one support is provided where residents are unable to participate in group activities such as foot spas, hand massage, discussions. Meaningful household activities include folding of washing, sorting, household chores and gardening. There are entertainers weekly, one resident plays guitar and entertains the other residents. Church services are held weekly, and communion is available for residents. There is one main lounge where group activities occur and two smaller lounges for quieter activities. Community visitors include RSA, church groups, hairdresser, Salvation Army choir and pet therapy. There are three home cats on site daily. Festivities and theme days are celebrated. There is small group daily outings Monday to Friday (weather permitting). An HCA accompanies the DT on outings. The DT has a current first aid certificate. There has been good attendance at the family meetings (held four monthly). A social history and resident profile are completed on admission and a 24-hour activity plan is developed in consultation with the resident (as appropriate) and the family and include aspects of the resident`s life and past routine. Activity progress notes are maintained. The resident’s activities plan is evaluated six monthly and documents progress towards meeting individual goals. Three family members interviewed spoke positively of the programme and the outings provided.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six monthly. Written evaluations identify if the resident goals have been met or unmet. Short-term care plans sighted were evaluated and added to the long-term care plan if the problem is ongoing. Where short term care plans related to infection, these have not always been signed off as reviewed or resolved.Where progress is different from expected, the service responds by initiating changes to the care plan. The relatives are involved in the evaluation process as confirmed on interviews.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness which expires on 1 June 2022. The manager oversees the maintenance programme. A maintenance log is used for maintenance requests which are addressed and signed off when complete. A handyman is available for small repairs. Corrective action plans are completed for repairs. There are essential contractors available 24 hours. A planned maintenance diary is maintained for testing and tagging, hot water checks, equipment calibrations and environmental maintenance. Hot water temperatures are recorded and are below 45 degrees Celsius. Contractors maintain gardens and grounds. The service is well maintained with home-like décor and furnishings. There is a large communal lounge and two smaller quiet lounges. There is easy access to the outdoors with ramps and rails. The unit has a secure garden and walking pathways to encourage purposeful walking. Residents were observed to be freely accessing the outdoor areas on the day of audit. The exterior is well maintained with safe paving, outdoor seating and shade.Interviews with HCAs confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The clinical nurse manager (RN) is the infection control coordinator. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility (link 1.2.7.5). Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Corrective actions are established where trends are identified and documented as followed up. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners. Systems in place are appropriate to the size and complexity of the facility. Covid-19 pandemic policies are available, and guidelines implemented. Visitors are asked not to visit if unwell. There is QR screening and declarations in place for all visitors and contractors that visit the facility. Hand hygiene notices are in use around the facility and there are hand sanitizers strategically placed throughout the buildings. Relatives have been kept updated on visiting policies for different Covid -19 lockdown levels. There was a confirmed norovirus outbreak in April 2021 reported to Public Health and managed appropriately for the time and duration (21 days). |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The use of enablers and restraint is reviewed through internal audits and meetings. Interviews with the staff confirmed their understanding of restraints and enablers. Staff completed annual training in restraint minimisation and the management of challenging behaviour.On the day of audit, there were no residents using restraints or enablers. The register confirmed the last restraint use was in September 2019.  |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | Monthly events for infections, accident/incidents and hazards are collected. There are monthly trending and analysis of data. There is an annual internal audit schedule that has been reviewed and implemented. All corrective actions have been signed as completed. The internal audit schedule had been completed as per schedule for 2020/2021. Meeting minutes reviewed identify accidents/incidents, infections, hazards, complaints/complements, restraint are discussed. The next internal audit due on the annual schedule is documented in the staff meeting minutes, but not any outcomes from the previous month`s completed audits. The results/outcomes of the relative survey results for 2019 and 2020 have not been communicated at staff meetings. | i). There is no documented evidence that internal audit outcomes have been reported at staff meetings. ii). The 2019 and 2020 relative survey results have not been collated and therefore outcomes have not been discussed or documented in monthly reports or meeting minutes. | i). Ensure internal audit outcomes are reported at monthly meetings.ii). The relative satisfaction survey results collated, analysed and communicated to relatives and staff.60 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | There is a planned schedule for compulsory training and for completion of annual competencies. The education schedule has been implemented for 2020 and on schedule for 2021. Healthcare assistants completed annual competencies and included medication, manual handling, restraint and handwashing. There is an education session and topic recorded monthly at the staff meeting. A list of education provided meets the compulsory education requirement under the contract. Health care assistants interviewed could describe the education topics they received, however there was no evidence on file of the content of the sessions, this is a continued shortfall. | The content of training or education topics has not been documented. | Ensure that the content of education sessions is documented.60 days |
| Criterion 1.3.8.2Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Long term care plans are evaluated at least six monthly or earlier as the resident health changes. Short term care plans are developed for a range of short and acute conditions. Five files were reviewed (one respite care). Two of four long term resident files reviewed evidence short-term care plans used for a urine tract infection, skin tear and unintentional weight loss that has been signed off as reviewed or resolved, however, not all current short term care plans had been signed off as resolved.  | Two of four long term files reviewed evidence short term care plans. These had been developed for a chest infection, knee infection, weight loss and vomiting but have not been signed off as resolved.  | Ensure short term care plans are signed off as evaluated and/or resolved.90 days |

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

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

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

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

|  |
| --- |
| No data to display |

End of the report.