# Lady Joy Home Limited - Lady Joy Rest Home

## Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Lady Joy Home Limited

**Premises audited:** Lady Joy Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 21 October 2021 End date: 21 October 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:** 20

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

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

Residents and family members interviewed were complimentary about the care provided.

This certification audit was undertaken to establish compliance with the Health and Disability Service Standards and the service’s contract with the District Health Board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, staff, the managing director/owner and a general practitioner.

An area requiring improvement relates to police vetting and reference checks for new staff.

## 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. |  | Standards applicable to this service fully attained. |

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents of Lady Joy Rest Home. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services at Lady Joy Rest Home are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

Lady Joy Rest Home has linkages with a range of specialist health care providers. This contributes to ensuring services provided to residents are of an appropriate standard.

The managing director/owner is responsible for the management of complaints and a complaints register is maintained. There have been no complaint investigations by the Health and Disability Commissioner or other external agencies since the previous audit

## Organisational management

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

A business plan, including a mission statement, philosophy and goals, and quality and risk management systems are fully implemented. Systems are in place for monitoring the service, including regular reporting and discussions by the clinical nurse leader to the managing director/owner.

The facility is managed by a managing director/owner who works in the business and is responsible for the overall operation of the facility. The facility has been owned by the current owner for approximately 21 years. The clinical nurse leader is an experienced registered nurse who has been in the position since August 2021.

There is an internal audit programme. Adverse events are documented on incident/accident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address any areas that require improvement including audits, satisfaction surveys and incident/accidents. Staff, quality and residents’ meetings are held on a regular basis. Actual and potential risks including health and safety risks are identified and mitigated.

Policies and procedures on human resources management are in place. Most human resources processes are followed. Staff have the required qualifications. An in-service education programme is provided, and staff performance is monitored. A documented rationale for determining staffing levels and skill mix is in place.

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

## 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. |  | Standards applicable to this service fully attained. |

Lady Joy Rest Home liaises with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriately managed. When a vacancy occurs, relevant information is provided to the potential resident and the resident’s family to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Residents care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents’ files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed. Residents and family/whanau reported being informed and involved in care planning and evaluation, and that the care provided is good. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

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

Residents’ bedrooms provide single accommodation. A lounge, dining area and alcoves are available. External areas for sitting and shading are provided.

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

An appropriate call bell system is available, and security and emergency systems are in place.

## 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. |

The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard and identifies the use of enablers is voluntary and the least restrictive option to meet residents’ needs. Lady Joy Rest Home is a restraint free environment and there were no residents using restraint or enablers during the audit.

## Infection prevention and control

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

The infection prevention and control programme, led by an appropriately trained infection control coordinator, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from the Whanganui District Health Board. The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, analysed and trended. Results are reported to all staff. Follow-up action is taken as and when required.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 44 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Lady Joy Rest Home (Lady Joy) has policies and procedures in place to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation’s standard consent form, including for photographs, outings, invasive procedures, and collection of health information.  Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s file. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day-to-day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were displayed in the entry foyer and on residents notice boards. Family members/whanau and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff were aware of how to access the Advocacy Service. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community. During Covid-19 restrictions, that limited contacts, this has been enabled by phone calls and emails. When there are no restrictions, residents are enabled to attend a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility at the time of audit had restricted visiting hours and encouraged visits from residents’ families and friends, within these restricted times. Family/whanau interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is additional complaints information available. Three complaints have been received since the previous audit. The register meets the requirements of Right 10 of the Code.  The managing director/owner (MDO) is responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required. Residents and families confirmed they knew how to make a complaint and who they would go to if needed.  There have been no complaint investigations by external agencies since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents (six) and family/whanau (three) interviewed, reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in the entry foyer together with information on advocacy services, how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and family/whanau confirmed that services are provided in a manner that has regard for the resident’s dignity, privacy, sexuality, spirituality, and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussions with families and the GP. All present residents at Lady Joy have a private room.  Residents are encouraged to maintain their independence by being enabled to participate in a range of activities and interests they have enjoyed in the past. Restrictions imposed by Covid-19 have minimised the opportunities to participate in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There was one resident and four staff members at Lady Joy who identified as Māori. Interviews verified that staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents confirmed that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A residents’ satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met, and this supported those individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family/whanau interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. Registered nurses (RN’s) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Lady Joy encourages and promotes good practice using up to date and referenced policies and accessing assistance from external specialist services and allied health professionals when guidance is required, for example, Whanganui District Health Board (WDHB), the hospice/palliative care team, wound care specialist, dieticians, services for older people, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. The GP was supportive in providing additional medical backup to Lady Joy during the recent RN shortage at Lady Joy.  Staff reported they receive management support to access in-service training opportunities, and access their own professional networks, such as on-line forums, to support contemporary good practice.  Other examples of good practice observed during the audit included the commitment of the caregivers to providing the residents, many who have been there for a long time, with supportive familiar care. The turnover of care staff at Lady Joy is low, and the caregivers have a diverse knowledge of the resident’s individualised needs. All residents interviewed expressed a high degree of satisfaction with the care provided by Lady Joy’s care staff. The recent employment of a skilled clinical RN provides the staff with good clinical guidance. Evidence was sighted of a recent improvement in wounds, noting several lesions have nearly healed. This improvement was noted by the visiting wound care nurse. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family/whanau of residents stated they were kept informed about any changes to their own/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family/whanau input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services can be accessed via WDHB when required. There were no residents at Lady Joy who required interpreter services at the time of audit, due to all present residents being able to speak English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lady Joy Home Limited is responsible for the services provided. A business plan includes a ‘SWOT’ analysis, mission, philosophy and goals. An organisation chart shows staff reporting lines. The managing director/owner works in the business and is on site daily. The clinical nurse leader (CNL) and managing director/owner discuss all matters pertaining to activities at Lady Joy, daily. Both the MDO and CNL confirmed this.  The clinical service is managed by the CNL who is a registered nurse with prior clinical nurse leadership experience. The CNL has been in this position since August 2021. Prior to this appointment there was a CNL employed in January 2021 following the resignation of the clinical nurse manager. The CNL resigned after being employed for a short period. The position was advertised; however, there was a gap where Lady Joy had no CNL/RN employed. The MDO stated this was covered by the facility’s GP and practice nurse. An RN was employed two months prior to the current appointment of a CNL and remains as a casual RN filling in for the CNL and working as needed. There was evidence in the CNL’s file of appropriate ongoing education.  The service’s philosophy and mission statement are in an understandable form and are available to residents and their family/representative or other services involved in referring residents to the service.  The facility can provide accommodation for up to 31 residents. On the day of this audit there were 20 residents assessed at rest home level under the aged related residential care contract. Lady Joy also has contracts including long term support-chronic health conditions, carer relief, intermediate care with the DHB and a contract with the Ministry of Health for residential non-aged care. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | If the MDO is temporarily absent, the two administrators fill the role. If the CNL is absent, the casual RN will fill in for the clinical service with support from the home’s GP and practice nurse. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality improvement plan and risk management plan include quality objectives and outcomes which guide the quality programme. This includes management of complaints, audit activities, resident/family satisfaction surveys, monitoring of outcomes and incidents/accidents, including skin tears, infections, medication errors and falls.  Quality data is collected, collated and analysed. Corrective actions are developed and implemented with evidence of reauditing when a deficit is identified and evidenced close out and sign off. Staff and quality meetings include quality, health and safety, infection control and restraint, and residents’ meetings are held regularly. Meeting minutes evidenced reporting back to staff of corrective actions and trends as a result of analysing quality data. Month by month graphs are generated for clinical indicators. Staff interviewed confirmed they discuss quality data and what corrective actions are required.  Resident/family satisfaction surveys for 2021 evidenced high satisfaction with the care provided.  Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies are reviewed at least two yearly and were current. Obsolete policies are destroyed. Updated policies are discussed at the staff meetings. All policies are held both electronically and in hard copy. Staff confirmed they are advised of updated policies, read, and sign off and that the policies and procedures provide appropriate guidance for service delivery.  The health and safety policy covers all aspects of health and safety management. Actual and potential risks are identified and documented in the hazard register. The register identifies hazards and risks including but not limited to clinical, environmental, staffing and financial and showed the actions put in place to minimise or eliminate risks. Newly found hazards/risks are communicated to staff. Hazards and safety issues are discussed at staff meetings. The health and safety representative is the administrator who is new to the role and demonstrated knowledge of health and safety. Staff confirmed they understood and implemented documented hazard/risk identification processes. |
| 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 | Staff document adverse and near miss events on an accident/incident form. These are reviewed by the senior caregiver on shift and forwarded to the CNL who is responsible for investigating if needed. Any incidents/accidents rated high risk and above are notified to the MDO. Each resident has a resident untoward event summary form on file. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and analysed by the CNL, and trends shared with staff through meetings. A month-by-month summary register is current, and staff are provided with month-by-month graphs. Residents’ families were advised of the incident/event on every form sampled.  The CNL and MDO were aware of essential notification reporting requirements. The MDO advised there have been no essential notifications sent to external agencies since the previous audit. The MDO reported the change of CNL prior to the current appointment was notified to HealthCERT. The current CNL was notified to HealthCERT during the onsite audit.  The auditors observed a resident during the audit who presented as being possibly hospital level. The MDO and CNL reported this resident has been assessed as hospital level care by the GP and the resident’s interRAI; however, an exemption had not been requested from HealthCERT. This was actioned during the audit. |
| 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 Low | Policies and procedures relating to human resources management are in place. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientation, competency assessments and training certificates. Not all staff files reviewed evidenced police vetting and reference checks.  New staff are required to complete the induction programme. They are ‘buddied’ with an experienced caregiver with support from the CNL for three to five shifts. The entire process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and yearly thereafter. Staff performance appraisals were current. Annual practising certificates were current for staff and contractors who require them to practice.  The education programme is the responsibility of the CNL and the RN. In-service education is provided for staff and documentation evidenced this is held at least monthly. Records are held for staff attendance at training sessions and competencies are completed including for medicine management. External educators provide some sessions. Staff have current first aid certificates, and these were sighted in staff files.  Staff are encouraged to complete a New Zealand Qualification Authority education programme. Eight caregivers have attained level 2, three have attended level 3 and two have attended level 4.  Staff confirmed they have completed an induction, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals. |
| 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 rostering and rationale policy documents the rationale for determining staffing levels and skill mix to provide safe service delivery.  The administrator and CNL reported the rosters are reviewed continuously and dependency levels of residents and the physical environment are considered. There is always at least one staff member with a current first aid certificate on each shift.  The managing director/owner works fulltime, and the clinical nurse leader works Monday to Friday approximately 9am to 1pm and longer if needed with a casual RN filling in as required. Two caregivers are rostered on the morning shift during the week and three rostered on over the weekend. Three caregivers are on the afternoon shift, and one is rostered on at night. The CNL is on call for clinical matters and the MDO for all other issues. Three casual caregivers are available if required. A diversional therapist, cleaners, cook, kitchen hands two administrators and a maintenance person are employed. The caregiver workforce is stable with a number having worked at Lady Joy for many years.  Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and families reported they are happy with the staffing levels and there are enough staff on duty to provide them or their relative with a high standard of care. Observations during the audit confirmed adequate staff cover is provided. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used on documentation as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.  Electronic medication records are stored in a secure portal. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are admitted to Lady Joy when they have been assessed by the local Needs Assessment and Service Coordination (NASC) Service, as requiring the level of care Lady Joy provides. Prospective residents and/or their families/whanau are encouraged to visit Lady Joy prior to admission and meet with the clinical nurse leader (CNL). They are provided with written information about the service and the admission process. It is the family/whanau/resident’s choice if they choose to be admitted to Lady Joy.  Family/whanau members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including progress notes, a referral document, medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. The family of the resident requested the resident to be transferred to seek more active treatment than was available at Lady Joy. |
| 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 | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using a recently implemented electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.  There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner if required.  Medication errors are reported to the CNL and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.  Standing orders are not used at Lady Joy. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service at Lady Joy is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian on 10 September 2021. Recommendations made at that time have been implemented.  An up-to-date food control plan is in place. A verification audit of that plan was undertaken in February 2021. No corrective actions were identified, and the plan was approved for 18 months.  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews, satisfaction surveys and from residents’ meetings minutes. Any areas of dissatisfaction are promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There was sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family/whanau are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNL. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission, residents of Lady Joy are assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, was evidenced to have occurred in September 2021. In five of six files reviewed, the interRAI assessment prior to September 2021 was not completed within six months, due to not having an RN onsite and Covid-19 restrictions.  In all files reviewed, initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission. Interviews, documentation, and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels (see 1.3.3.3, tracer detail).   All residents have current interRAI assessments completed by two trained interRAI assessors on site. InterRAI assessments are used to inform the care plan. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | All the care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations, and interviews verified the provision of care to residents was consistent with their needs, goals, and the plan of care. A resident with a potential to wander, has a wander search monitor in place, to keep the resident safe. There was no evidence of recent wandering following a behaviour management strategy that has resulted in the resident having no desire to wander anymore. Two residents with wounds, have had recent improvements, with the wounds nearly healed, following the appointment of the new experienced RN and the input from the wound care nurse specialist. All residents with wounds are noted in the care plan to be provided with a high protein diet. Wound care products as per the advice of the wound care nurse are available at Lady Joy.  The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a good standard. Care staff confirmed that care was provided as outlined in the documentation.  A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided at Lady Joy by a diversional therapist (DT) four days a week. The DT is new to the role, starting in September 2021. Prior to that, an activities coordinator had provided the activities.  A social assessment and history are undertaken on admission to ascertain residents’ needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated regularly and as part of the formal care plan review every six months.  The planned monthly activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and included normal community activities, when Covid-19 restrictions permit. Individual, group activities and regular events are offered. Examples included daily walks, bingo, scenic drives, music, visiting entertainers, quiz sessions, ‘sit fit’, and daily news updates. Several the residents have their own interests that they do by themselves, and the DT supports this as required.  The activities programme is discussed at the monthly residents’ meetings and minutes indicated residents’ input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the activities offered at Lady Joy. Residents interviewed confirmed they find the programme meets their needs. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples are sighted of short-term care plans being consistently reviewed for infections, pain, and weight loss. Progress is evaluated as clinically indicated and according to the degree of risk noted. Wound management plans were evaluated each time the dressing was changed.  Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or CNL sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to the wound care nurse specialist. Referrals are followed up on a regular basis by the CNL or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.  Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. Evidence of this was sighted following a resident’s recent transfer to WDHB. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are throughout the facility and accessible for staff. The company representative that supplies chemicals, visits monthly and provides training. Education to ensure safe and appropriate handling of waste and hazardous substances has been provided to staff.  Protective clothing and equipment were appropriate to recognised risks, observed in the laundry and being used by staff. Staff demonstrated a sound knowledge of the processes relating to the management of waste and hazardous substances. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed at the main entrance that expires on the 22 June 2022. The facility and external environment are maintained to an adequate standard. A preventive and a reactive maintenance programme is in place and hot water temperatures are within the recommended range. Testing and tagging of equipment and calibration of biomedical equipment was current. Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.  There are areas throughout the facility for residents to frequent. Gardens, lawns and outside furniture is available for residents to enjoy. Surfaces, both internal and external are mainly flat with ramps and safety rails leading to the outside. Residents were observed to easily manage with mobility aids. Passageways are wide enough for residents to pass each other and communal rooms have easy access. Residents and families stated they can move freely around the facility and that the accommodation meets their needs.  Residents and families confirmed they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | One room has a full ensuite and two others have a toilet and wash hand basin. There are adequate showers and toilets located throughout the facility. Locking devices were observed for privacy.  Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence.  Resident and families interviewed reported that there were sufficient toilets and showers and that they are easy to access. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is a mix of bedroom sizes. Bedrooms are large enough to provide personal space for residents and allow of staff and equipment to move around safely. Rooms are appropriately furnished and maintained. Residents interviewed spoke positively about their accommodation. There is room to store mobility aids. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Several areas are provided for residents and families to frequent for activities, dining, relaxing and for privacy. The areas are easily accessed by residents and staff. Residents, families and staff confirmed this. Furniture is appropriate to the settings and arranged in a manner which enables residents to mobilise freely. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is washed and dried on site. Cleaning and laundry is undertaken by household staff. The facility is cleaned to an adequate standard. Staff demonstrated a sound knowledge of processes. Chemicals are stored securely. All chemicals were in appropriately labelled containers. A closed system for chemicals is currently being installed. The company representative visits monthly and provides on-going training for staff. Cleaning equipment and linen bags are colour coded for different uses. Cleaning and laundry processes are monitored through the internal audit process. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The evacuation scheme was approved by the New Zealand Fire Service on 13 September 2004. Fire drills are completed six-monthly, the last one held on the 11 May 2021. There have been no building alterations since the previous audit. The emergency plan details emergency preparedness. Staff confirmed their awareness of emergency procedures and training has been provided. The orientation programme includes fire and security training. All required fire equipment has been checked and was current.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and a gas BBQ. Emergency battery power is provided. A call bell system alerts staff to residents who require assistance.  The doors are locked in the evenings and sensor lights are situated externally. Staff also complete security checks. Security cameras are situated in communal areas and external doors. Notices at external doors advise visitors of the security cameras operating. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Heating is either via electric panel heaters or ducted from the ceiling with individual thermostats in the bedrooms. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All residents’ rooms have natural light. The service has an external covered area for smokers. Residents and families confirmed the facility is maintained at a comfortable temperature. During the audit, the temperature was appropriate in all areas. |
| Standard 3.1: Infection control management  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. | FA | Lady Joy provides a managed environment that minimises the risk of infection to residents, staff, and visitors through the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the CNL. The infection control programme and manual are reviewed annually.  The CNL is the designated infection control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported on monthly and tabled at the quality/risk and staff meetings. Infection control statistics are entered in the organisation’s electronic database. The organisation’s owner is informed of any IPC concern.  Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator (ICC) has appropriate skills, knowledge, and qualifications for the role, however, has been in the role for only a short time. The ICC has undertaken training in infection prevention and control and attended relevant study days. Well-established local networks with the infection control team at the WDHB are available if required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. A Covid-19 management plan was sighted. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.  Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICC. The infection control nurses from WDHB trained the staff at Lady Joy on the use of personal protective equipment (PPE) use and donning and doffing of PPE. Training on wound care was done in April 2021 and May 2021 by the WDHB. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained.  When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education had been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. Education has been provided on Covid-19. Three of the residents are waiting for their second dose of the Covid-19 vaccination. One has refused. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance of infections at Lady Joy is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident’s clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  The ICC reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation’s electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.  A good supply of personal protective equipment is available. Lady Joy has processes in place to manage the risks imposed by Covid-19. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes a definition, assessment and evaluation and complies with the requirements of the standard. The CNL reported Lady Joy is a restraint free environment and the aim is not to use any form of restraint. The MDO advised that restraint has never been used at Lady Joy. There were no residents using a restraint or enablers at the time of audit. Equipment includes sensor mats, landing pads and high/low beds. Staff interviewed demonstrated knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | The recruitment policy includes the process for recruiting staff, including interviews and requesting information (e.g., police vetting). Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientation, competency assessments and training certificates. Three of the five staff files reviewed did not have evidence of police vetting and reference checking. | Not all staff employed have had reference checks or police vetting undertaken. | Provide evidence that all staff have police vetting and reference checks completed.  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.

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End of the report.