# Springlands Senior Living Limited - Springlands Lifestyle Village

## 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:** Springlands Senior Living Limited

**Premises audited:** Springlands Lifestyle Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 13 January 2022 End date: 14 January 2022

**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:** 59

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

Springlands Lifestyle Village (Springlands) provides rest home and hospital level care for up to 56 residents in the care centre. There are also 20 serviced apartments certified to provide rest home level care. On the day of audit there were 59 residents including three residents at rest home level in the serviced apartments

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

An experienced and appropriately qualified village manager has been in the position for eleven years. The village manager is supported by a care service manager, operations leader, and food service leader. They are supported by a team of registered nurses, healthcare assistants and non-clinical staff. Residents and relatives overall commented very positively on the services and care received at Springlands.

There is an established quality and risk management system. Residents and families interviewed commented positively on the standard of care and services provided.

This surveillance audit identified improvement required around staff training, care documentation and medication management.

## 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 service is committed to a culture of open disclosure. There are effective communication processes at all levels of service delivery. Families are regularly updated of residents’ condition including any acute health changes or incidents. Residents and family member interviewed verified ongoing communication regarding Covid19 preparedness strategies. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

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

Springlands are implementing the organisational quality and risk management system that supports the provision of clinical care. A village manager, care service manager, operations leader and food service leader are responsible for the day-to-day operations of the facility. Quality activities are conducted, and this generates improvements in practice and service delivery.

Meetings are held to discuss quality and risk management processes. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training programme is in place. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Registered nursing cover is provided 24 hours a day, 7 days a week.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Registered nurses’ complete initial assessments including interRAI assessments, care plans and evaluations within the required timeframes. Care plans are integrated and include the involvement of allied health professionals. Residents and relatives interviewed confirmed they were involved in the care planning and review process. General practitioners review residents at least three monthly or more frequently if needed.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting and includes outings, entertainers, and community interactions.

There are medication management policies to guide the staff in the management, storage, and administration of medication. Registered nurses and senior healthcare assistants administering medications have completed annual competencies. The general practitioners reviewed the medication charts at least three-monthly.

Meals are prepared and cooked on site under the direction of a food service leader. A dietitian reviews the menus. The menu is varied and provides meal options. Individual and special dietary needs are catered for. Residents interviewed were complimentary of the food service.

## Safe and appropriate environment

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

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place and include testing of equipment and maintaining safe water temperatures. There is sufficient space to allow the movement of residents around the facility with hallways and communal areas being spacious and accessible. External areas are safe and well maintained with shade and seating available.

## 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. |

Restraint minimisation and safe practice policies and procedures are in place. Staff receives training in restraint minimisation and challenging behaviour management. On the day of audit, the service had no residents using restraint and one with an enabler.

## 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 control officer (care service manager) is responsible for coordinating/providing education and training for staff. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There is a monthly surveillance programme, where infections are collated, analysed, and trended with previous data. Where trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported at the various meetings. There is evidence of education and staff involvement with any infections that are identified during the surveillance programme. Covid 19 prevention strategies aligns with the national Covid19 preparedness framework. There have been no outbreaks since the previous audit.

## Summary of attainment

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

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| **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 | 13 | 0 | 0 | 3 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 0 | 3 | 0 | 0 |

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| **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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure is provided to residents and relatives on entry to the service. The village manager maintains a record of all complaints, both verbal and written, by using a complaint register. Management interviewed confirmed they have an open-door policy, and all concerns are dealt with in a timely manner. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. Interviews with residents and relatives, confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting of complaints.Eight complaints have been logged for 2020 and 2021 since the last audit. All complaints documented a comprehensive investigation, follow-up, and replies to the complainant. Complaints all included a section to confirm that the complainant was happy with the outcome. Resolution letters reviewed evidence information is provided regarding advocacy services. There were no complaints lodged to external agencies. Discussions with residents and 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.  |
| 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. Management interviewed (village manager, care service manager, food service leader) confirmed family are kept informed. Relatives interviewed (two hospital) stated they are notified promptly of any incidents/accidents or changes in care. Three residents interviewed (one hospital, two rest home residents including one in the serviced apartments) stated they are involved and kept informed of any changes to their own care and feel informed about the service`s Covid 19 prevention strategies. Seven staff interviewed (four healthcare assistants [HCAs], one RN, one diversional therapist and a health and safety representative) were able to describe the process around open disclosure.Thirteen accident/incident forms and progress notes reviewed evidenced relatives are informed of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Access to interpreter services is available if needed for residents who are unable to speak or understand English. Family and staff are used in the first instance. Registered nurses completed clinical excellence training including communication with families after adverse events or deterioration of a resident. Communication to families related to Covid-19 is published newsletters, memos and individual emails are sent to relatives. The overall pandemic response plan clearly defines communication channels.Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services, premium rooms, and any items they have to pay for that are not covered by the agreement.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Springlands Lifestyle Village provides rest home and hospital (medical and geriatric) level care for up to 56. All rooms in the hospital and rest home wings are dual-purpose including 11 studio apartments (downstairs). There are 20 serviced and independent apartments (upstairs) that are certified for rest home level care. There is a total of 76 beds.On the day of audit, there were 59 residents. There were three rest home residents in the serviced apartments (upstairs). There were 56 residents in the rest home/hospital (downstairs). There was a total of 23 residents at hospital level including two respite residents, and 36 residents at rest home level (upstairs and downstairs), including two respite residents and one resident on a private contract. All residents were under the aged residential care contract (ARRC).A philosophy, mission statement and key values are documented. The business plan (2020-2022) is regularly reviewed by the village manager and managing director. The village manager and managing director reported that they meet regularly to review the progress towards the goals. Progress towards the goals are shared with staff during meetings. The service is overseen by a board of directors. The village manager documents quarterly reports to the board and shareholders and monthly reports to the managing director. The village manager (non-clinical) has been in the position for eleven years with a New Zealand Diploma in Management. A care service manager (registered nurse) is employed to oversee the running of the rest home and hospital and has completed eight hours of professional development related to managing an aged care facility. The care service manager has been in the role for four months and has previous management experience in aged care. |
| 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. | FA | Springlands continues to implement the quality and risk management programme which has been purchased from an external consultant. These policies are current and regularly updated to comply with current good practice, changes in standards and legislation. Internal audits, data collection, collation of data are all documented as taking place with remedial actions completed in a timely manner. Two monthly staff meetings, weekly management meetings, three monthly infection control and health and safety meetings, as well as two monthly clinical meetings ensure that quality data is communicated, discussed and issues acted upon in a timely manner. The clinical meetings include resident care studies and reflective practice as a learning and development process for the RNs. Covid 19 preparedness is evident at all levels of service delivery and strategies are well documented to reflect the current Covid19 response framework.A review of the November 2020 resident and relative survey results evidences an overall improvement from 2019. Corrective actions were implemented to work towards the improvement of meals and drinks. The survey for 2021 had been distributed at the time of the audit. 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. The service collates incidents and accidents and infection control outcomes and implements action plans when the service falls outside the industry norm limits set by the electronic data base. The service was awarded a rating of continuous improvement at the last audit, and the same strategies continues to be implemented.A health and safety system is in place with identified health and safety goals. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. Hazard identification forms and an up-to-date hazard register is in place. The health and safety officer (administrator) interviewed stated there were no staff injuries were reported or managed in the last 12 months. Staff completed manual handling and transfer competencies and annual training in falls prevention.  |
| 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 | Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is collated online and benchmarked across comparable services. Thirteen resident related accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Incidents are analysed for trends. Neurological observations are conducted for suspected head injuries and unwitnessed falls. The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There were three section 31 notifications made in 2020 for stage three pressure injuries (facility acquired). In 2021 year to date three notifications have been made including for two pressure injuries (one stage four and one stage three non-facility acquired pressure injuries) and one HealthCERT notification for the change in care service manager. There have been no outbreaks since the last 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 Moderate | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (kitchen assistant, two HCAs, one RN and the care service manager) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of RN and allied health professionals practising certificates are maintained. The service has an orientation programme in place that provides new staff with relevant information specific to their roles and for safe work practice and includes buddying when first employed. The initial orientation and associated documentation are completed in a timely manner.Staff need to be fully vaccinated against Covid19 to commence or continue with employment. Education sessions include Covid 19 preparedness and drills, using of PPE and isolation precautions.A competency programme is in place. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files included: cultural, restraint, manual handling, medication, hand hygiene, use of personal protective equipment and medication). The annual education planner was documented for 2020 and 2021 however not implemented. The 2022 education planner is being implemented for 2022. The attendance numbers for compulsory topics in 2020/2021 were below 50%.The 29 healthcare assistants undertake aged care education (Careerforce) with currently 15 on level 4, three on level three and three on level two. All RNs and senior healthcare assistants have obtained a first aid certificate and there is at least one person on a shift with a current first aid certificate. There are six RNs working at Springlands and five have completed interRAI training.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a staffing rational and policy, staffing levels meet contractual requirements. The management team includes: the village manager Monday to Friday, the operations leader Monday-Friday (managing gardening and maintenance staff), Food Service leader and the care service manager. Staffing includes:The care service manager works Monday- Fridays 8am-4.30pm and is on call after-hours with other registered nurses. Rest home (Springlands and Willowmeade): 33 beds and 33 residents (and three in the serviced apartments)Registered nurse Tuesdays – Thursdays 7am-3.30pmAM-HCA team leader (medication competent) Friday-Monday 7am-3.30pm, one HCA 7am-3pm and one 7am-1pm each day of the week, and one HCA 7am-1pm for the service apartmentsPM- HCA team leader (medication competent) 3pm-11.15pm, one 3pm- 9.30pm and one for the service apartments 4pm-8pm.NIGHT-one HCAHospital (Wisteria): 23 beds and 23 residentsRegistered nurses; AM - one RN hospital Monday to Sunday 7am-3.30pm, PM and night - one RN for each shift.Healthcare assistants: AM - two long shifts 7am-3.15pm and two short shifts 7am-1pm PM - two long shifts3pm-11pm and one short shift 4pm-8pmNIGHT - one HCA.The registered nurse rostered in the hospital will oversee the rest home where the registered nurse or care service manager is not available or rostered. Healthcare assistants interview confirm adequate staff skill mix and experience for the acuity of the residents. Staff confirmed they can extend their hours to complete tasks or when acuity of residents’ changes. Interviews with the residents and relatives confirmed staffing overall was satisfactory.  |
| 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. | PA Moderate | The medication management system includes a medication policy that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely. Registered nurses and senior HCAs complete annual medication competencies and medication education. Medication reconciliation occurs against the robotic rolls (for regular medications) and blister packs (for as required medications). Several entries in the controlled drug register were incomplete. There were no standing orders or hospital impress stock.Records of medication reconciliation are entered into the electronic medication system. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. There were two rest home residents self-medicating with current self-medication competencies. The medication fridge temperature and medication room temperature are being monitored daily and both were within acceptable limits. There were open undated food related products in the in the dedicated medication fridge, and not all eyedrops were dated on opening. Ten medication charts on the electronic medication system were reviewed. All charts had photo identification however three photos were more than 18 months old and allergy status were not documented on three charts. The effectiveness of ‘as required’ medications were recorded in the electronic medication system. All long-term medications charts had been reviewed by the GP three monthly. |
| 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 | The food service leader is a qualified chef and have been with the service for almost ten years. All meals are prepared and cooked on site at Springlands Lifestyle Village. The food service level is supported by cooks and kitchenhands. There is a 8 weekly seasonal menu which has been reviewed by a dietician. The main meal is served at dinner with a lighter option offered at lunch. The menu offers a second meal option At dinner time for premium level care residents. Dietary needs are known with individual likes, dislikes and allergies/sensitivities accommodated. Pureed meals (using moulded shapes), mince and moist and vegetarian and gluten free meals are provided. Meals for residents in the rest home are plated from the bain-maire and served to residents in the adjacent dining room. Meals are plated and delivered in hot boxes to the hospital and service apartment dining room. Lunch was observed in the hospital dining room and there were plenty of staff at hand to provide assistance with their meals. Modified utensils are available for residents to maintain independence with meals.Healthcare assistants interviewed are knowledgeable regarding a resident’s food portion size and normal food and fluid intake and confirm they report any changes in eating habits to the RN and record this in the progress notes. A food control plan has been verified and expires June 2023. There are daily chiller, fridge and freezer temperatures taken and recorded. End-cooked food temperatures are taken. Cleaning schedules are maintained, and chemical are stored safely. Dishwasher rinse and wash temperatures are monitored. Food services staff have completed food safety and hygiene and chemical safety. Residents and relatives have the opportunity to feedback on the food services through resident and relative meetings and surveys. Residents and relatives commented positively on the food service leader open door policy and the meals provided.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | When a resident’s condition changes the RN initiates a GP or nurse specialist consultation. RNs interviewed stated that they notify family members about any changes in their relatives’ health status. Family members interviewed confirmed this. Conversations and notifications are recorded in the electronic progress notes. Not all care plans reviewed had detailed interventions recorded to meet the needs of the residents. Care plans did not always reflect the most recent assessments scores and information. There were 24 wounds (11 in the rest home and 13 in the hospital) including skin tears, abrasions, chronic leg wound, surgical wound, lesions and two stage two pressure injuries (facility acquired). Wound assessments had been completed for all wounds including a body map, sizes and photos as required. Evaluations and change of dressings had occurred at the documented frequency. Chronic wounds had been linked to the long-term care plan. Two hospital level care residents had a facility acquired stage two pressure injury on the heels. The RNs can access advice and support from the district nurses and wound nurse specialist at the DHB. There was sufficient pressure relieving devices in use and available. There is specialist continence advice as required. There is sufficient amount of continence stock at hand. A continence advisor is available and can be consulted when required.Monitoring records sighted included weights, vital signs, neurological observations, bowel records, food and fluids, blood sugar levels, pain, two hourly repositioning charts, fluid balance and challenging behaviour monitoring charts. Resident weights were noted to be monitored monthly or more frequently if necessary.  |
| 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 employees a qualified diversional therapist (DT) 8.30 am -4 pm four days a week to implement the activity programme in the rest home and another qualified DT from 9 am – 4 pm in the hospital from Tuesday to Friday. The facility is in the process of recruiting for a DT to cover the 5th day that is not currently covered by a DT. Residents in the serviced apartments are encouraged to join in activities. Each resident has a weekly activity calendar in big print, this is also put on notice boards. Each DT implements the resident programme in their area and includes (but not limited to); exercises, discussions, yoga, newspaper reading, quizzes, craft, ball games, walks, poetry, event celebrations and story hour. Activities meet the cognitive, physical, and emotional abilities of the residents. Individual activities are provided in resident’s rooms for residents who choose not to participate in the group activities. There is a weekly knit ‘n knatter group. The monthly men’s shed (on site) is facilitated by the maintenance person. Celebrations and festive occasions are celebrated. There are regular community visitors including church groups, pet therapy and entertainers. The community centre in the village hosts the bridge club and other community events such as the Christmas market day. There are regular outings and scenic drives to cafés, picnics, and places of interest. The service hires a wheelchair mobility van for hospital level residents for outings. During Covid-19 lockdown, the service-initiated zoom sessions for all residents to maintain communication with families, which was managed on a day-to-day basis by the activities team. The DT completes a resident profile on or soon after admission and takes a social history that identifies individual interest, person’s identity/life, and past routines. This information is then used to develop a diversional therapy plan which is evaluated six-monthly as part of the interRAI and care plan review/evaluation process. Residents and relatives have the opportunity to feedback on the programme through two monthly resident meetings, six monthly relative meetings and annual surveys. Residents and relatives interviewed were complimentary of the activities offered. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The initial care plan is evaluated in consultation with the resident/relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review (MDT) with the RN and DT. There is a written evaluation against the resident goals that identifies if the goals have been met or unmet. Long-term care plans are updated with any changes to meet the resident goals. Short-term care plans were evident for the care and treatment of short-term problems for residents’, and these had been evaluated, closed, or transferred to the long-term care plan if the problem was ongoing.  |
| 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 facility has a current building warrant of fitness that expires 19 April 2022. There is a maintenance person during the week who reports to the operations leader. The operations leader has overall responsibility for building compliance and is on call for maintenance issues. There is a maintenance and repairs request book at the front entrance that is checked daily and signed as repairs are completed. The planned maintenance programme has been completed to date, including electrical testing, and tagging of electrical equipment, calibration and testing of clinical equipment, monthly call bell audits and monthly hot water temperatures. Hot water temperatures in resident areas are maintained below 45 degrees. Essential contractors are available 24-hours. The care centre is located downstairs and the service apartments upstairs. There is an elevator and emergency stairs available for easy access between the floors. The elevator is spacious to accommodate ambulance transfer equipment if required. The physical environment allows easy access/movement for the residents and promotes independence with appropriately placed handrails and for residents with mobility aids. There is ramp access to the outdoors with landscaped gardens and raised garden beds. There is outdoor seating and shade provided. There have been no alterations to the building since November 2019 and the village manager confirm painting of rooms and communal areas, carpet and drape cleaning is part of the annual maintenance schedule. New heat pumps were installed in the hospital wing and an upgrade to the underfloor and hot water heating system.The RNs and HCAs interviewed stated they have all the equipment required to deliver safe resident care.  |
| 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 the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Infection monitoring is the responsibility of the IC coordinator (the care service manager). All infections are entered into the electronic database, which generates a monthly analysis of the data and includes benchmarking against other similar services. There is an end of month analysis with any trends identified and corrective actions for infection events above the industry key performance indicators. There are monthly and annual comparison of infection events. Outcomes are discussed at the infection control team meeting, registered nurse, staff, and management meetings. The GPs also monitor and review the use of antibiotics. There were no outbreaks since the last audit.A Covid-19 preparedness framework is implemented at all levels of service delivery. All visitors to the facility are required to sign in electronically, wear a mask, show a vaccine passport on entry, complete a health declaration including temperature checks and covid QR scanning. Outbreak management including Covid 19 preparedness specific training was completed in November 2021.  |
| 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. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation of any restraint and enablers is reviewed through internal audits, clinical and staff meetings. Interviews with the staff confirmed their understanding of restraints and enablers. Restraint and challenging behaviour training completed in November 2021. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, there were no residents with restraint and one resident with a lap belt enabler. The resident’s file included the enabler, any risks associated with its use, and monthly review of the enabler. Two hourly checks were documented as charted when in the chair.  |

# 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 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | A training matrix as part of the staff education policy provides guidance of specific core and other clinical related topics specific to Springlands that need to be completed throughout the year. The service implemented two annual full study days to ensure the training topics are covered. The village manager interviewed confirmed prior to 2020 staff were allocated to specific training days however in 2020/2021 due to Covid 19 strategies staff attendance was not scheduled, and staff could choose which days to attend. Training records, attendance and content are maintained however clinical topics (including diabetes management of chronic heart failure) identified in the training policy did not occur for 2020 and 2021 and one training day that covered intimacy and sexuality, communication, death and dying and risk management and hazard reporting evidence poor attendance for 2020 and 2021. | (i). Clinical related topics identified in the training policy specific to the residents of Springlands did not occur for 2020 and 2021.(ii). Training related to compulsory topics were poorly attended. | (i). Ensure clinical related training identified in the policy is completed.(ii). Ensure a scheduled approach to education to improve the number of attendees for compulsory training/topics.60 days |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | There is a medication management policy that meet legislative requirements and guidelines. Controlled medication is signed for on the electronic medication system by two medication competent staff. There are two registers (one for the rest home and one for the hospital), on the day of the audit entries were counter checked by the auditor against the electronic charts and progress notes. Two signatures appear in the electronic charts and register related to controlled medication. Not all entries in the register were fully completed. Weekly stock checks are completed, and six-monthly pharmacy reconciliation and quantity stock take and audit are documented. There is a list of sample signatures of staff that are medication competent. Training records sighted evidence all medication competencies are current.The medication trolleys were cleaned and safely stored in a locked room. Eye drops stored in the trolley drawers were not always dated when first opened.A medication internal audit was in December 2021 with a 100 % result. Annual medication management education occurred in June 2021. Five of ten electronic medication charts were reviewed did not meet good practice guidelines as set out in the service medication management policy and medication guidelines for aged residential care.  | The following shortfalls were identified:(i). Several entries in both controlled medication registers (rest home and hospital) were incomplete with missing times of administration and name of prescriber. (ii). Two eye drops on the hospital medication trolley were not dated when first opened.(iii). There were open food products in the dedicated medication fridge in the hospital treatment room.(iv). Two hospital resident electronic medication charts did not have the allergy section completed on the chart as per the policy requirements.(v). Three of ten photo identifications (one hospital and two rest home) were older than 18 months.  | (i)-(v). Ensure that medication management processes comply with medication management policies, good practice and related guidelines and legislation.60 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Five files were reviewed. Three of five files had an InterRAI assessment completed within the required timeframes; care plans addressed the scores and outcomes of the InterRAI assessments and documented individualised goals. One of three hospital residents care plans did not reflect the most recent falls assessment score and timely GP intervention. The two respite care residents did not require and InterRAI assessment. Care plans evidence documented interventions. However, one of two rest home resident files reviewed did not evidence documented interventions to a level of detail that can sufficiently guide staff in the management of the resident medical needs. Healthcare assistants and the registered nurse interviewed stated they are knowledgeable with the care requirements of all residents. Supplementary documentation including monitoring forms and progress notes evidence the residents are appropriately cared for.  | The following shortfalls were identified:(i). One hospital resident (tracer) had fourteen falls (no injuries) in 90 days, the falls risk assessment outcome was documented as medium in the care plan. There was no GP input sought at the time of the recurrent falls. Information relayed to the general practitioner at the time of the three-monthly medical review noted `no concerns` related to falls.(ii). The resident on respite care(tracer) with respiratory symptoms and lower leg oedema related to chronic heart failure care plan did not evidence interventions to manage oedema, medication management related to pain and oedema, weight monitoring requirements, tubigrip on the legs and respiratory symptoms.  | (i). Ensure care plans reflect the most recent risk assessment scores/outcome and ensure the GP is consulted in a timely manner when recurrent/frequent falls occur.(ii). Ensure the care plan document detailed interventions to meet all the needs of the resident.60 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.