The Whalan Lodge Trust - Whalan Lodge

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	The Whalan Lodge Trust
Premises audited:	Whalan Lodge
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 May 2019 End date: 16 May 2019

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 11

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Whalan Lodge is a 14-bed rest home, which is owned and governed by a community trust board. On the day of the audit, there were 11 residents. The manager at Whalan Lodge has been in the role since 2017 and is supported by an assistant manager and a part time clinical manager who is a registered nurse. Residents and relatives interviewed spoke positively about the care and support provided.

This surveillance audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, a family member, staff and management.

The service has addressed nine of twelve findings from the previous audit around informing family of incidents, internal audits, the hazard register, human resource documentation, staff training, care plan evaluation, medication management, food storage and hot water temperatures. Further improvements continue to be required around care planning interventions, monitoring and activities plans.

Consumer rights

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

Communication with residents and family was evidenced in care plans and confirmed on interviews. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The Whalan Lodge community trust board provides governance and support to the manager. The service has contracted an external quality consultant since the previous audit. There is a documented quality programme. Internal audits are completed as per the audit schedule. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are appropriately managed. A roster provides appropriate coverage for the effective delivery of care and support for residents.

Continuum of service delivery

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

The clinical nurse manager takes primary responsibility for managing entry to the service. Comprehensive service information is available. The clinical nurse manager completes initial assessments, including interRAI assessments and complete care plans and evaluations. Initial care plans are documented on admission. Risk assessments are completed and reviewed six monthly. The care plans reviewed were pre-printed for each aspect of care. Care plans are evaluated six monthly. The residents and relative interviewed confirmed their input into care planning and access to a typical range of life experiences and choices.

Activities were provided either within group settings or on a one-on-one basis.

There are medication management policies in place. Staff responsible for medicine management have current medication competencies. There were no residents who self-administer medicines at the facility.

Nutritional needs of residents are provided in line with resident needs and residents commented positively on the food service provided.

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.

Whalan Lodge has a current building warrant of fitness. There is reactive and preventative maintenance at the facility.

Residents' rooms are spacious and allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can access areas for privacy, if required. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and in communal areas. External garden areas are available with suitable pathways, seating and shade provided.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Whalan Lodge has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents with restraint or enablers.

Infection prevention and control

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

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	14	0	0	3	0	0
Criteria	0	40	0	0	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaints forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at the entrance. The service has a complaint's register on the electronic system. One relative made comment about never having to complain as they were very happy with the care, however they were aware of the complaint forms at the front door, and felt the management were available to answer any queries. No complaints have been received since the previous audit. A complaints procedure is provided to residents within the information pack at entry.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	Five residents and one relative interviewed confirmed that the staff and management are approachable and available. Ten accident/incident forms reviewed identified that family were notified following a resident incident. The previous finding has been addressed. Relatives are invited to attend the six-monthly resident/relative meetings. Interpreter services are available as required.

communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Whalan Lodge is governed by a community trust board, which includes eight board members. Whalan Lodge is a 14-bed rest home. On the day of the audit, there were 11 residents all under the age related residential care (ARRC) contract. The Whalan Lodge facility manager has been in the position since September 2017. She has a background in hospitality. The facility manager (FM) reports to the governing board monthly on a variety of topics relating to quality and risk management. The facility manager is supported by a clinical nurse manager (CNM) who is a registered nurse and has been in the role since July 2017. They are supported by an assistant manager/carer support/relief cook, a casual RN, care staff, the trust board and volunteer members of the community. The service has a current strategic and business plan, which includes a philosophy of care, and a current quality and risk management plan. Both the facility manager and clinical nurse manager have completed eight hours of professional development in relation to managing a rest home.
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	Whalan Lodge has implemented an electronic quality and risk management system. The facility managers' monthly report to the board of trustee's covers staffing, resident occupancy, accident/incident data, and any complaints/compliments. The service has in place a range of policies and procedures to support service delivery that are developed by an external consultant and reviewed regularly. Two caregivers and the kitchen manager as well as the RN/CNM confirmed they are made aware of new/reviewed policies. Quality data analysis related to incident and accidents, infection control, restraint and complaints are collected electronically. Monthly staff/quality meeting minutes included discussion around quality data analysis and what actions were required by staff. There is an annual internal audit calendar schedule in place, all audits have been completed as per the required schedule since June 2018. The results have shown an increase in compliance throughout the audit schedule. Corrective actions required for internal audits that are not compliant have been fully completed and signed off. The previous audit has been addressed. There is a health and safety and risk management system in place including policies to guide practice. Health and safety is discussed at the monthly staff/quality meetings. Hazard identification forms are completed for any accidents or near misses, a hazard register in place, which was developed in September 2018. The previous finding has been addressed. The resident/relative satisfaction survey was completed in June 2018, all residents/relatives surveyed were satisfied with the quality of the service being provided. Lower satisfaction was noted with the food services. Since the 2018 survey there have been changes in the dining room to include smaller tables to create a more sociable environment with more conversations. There have been more homemade soups featured in the winter

		menu and salads in the summer menu. The 2019 survey has not yet been completed. The service plans to complete another survey around food services prior to the dietitian visit on 30 May 2019, so residents can have an input to the new menu. Fall prevention strategies are in place that include the analysis of falls accident/incidents and the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Ten accident/incident forms were reviewed for April and May 2019 on the electronic system. All document timely RN review and follow-up, neurological observations were fully completed for all unwitnessed falls for falls with a potential head injury. The previous finding has been addressed. All ten incident forms indicated next of kin had been informed of all injuries. Discussions with the facility manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There have been no section 31 notifications lodged 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.	FA	Five staff files reviewed (one clinical nurse manager/RN, two caregivers, one lodge support, and one cook) included evidence of the recruitment process including police vetting, signed employment contracts and job descriptions. Reference checks, and an orientation were documented for one staff employed since the last audit. All appraisals are current in the files reviewed. The previous findings have been addressed. A current practising certificate was sighted for the clinical nurse manager/RN. There are two RNs (CNM and one casual RN) that have completed interRAI training. There is an annual in-service training calendar schedule, which includes all compulsory training and exceeds the eight hours training required. The caregivers interviewed stated they have enjoyed the training sessions offered since the last audit. The training schedule is fully implemented. The previous finding has been addressed. All staff are first aid trained.
Standard 1.2.8: Service Provider Availability	FA	Staff rostering, and skill mix policy is in place. Staff are rostered on to manage the care requirements for the 11 residents in the rest home. The facility manager is available from Monday to Friday. The clinical nurse manager works (between 24-26 hours per week) on Monday, Wednesday and Friday. Senior caregivers share the 24/7 on

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		call duty with support from a designated RN and the facility manager as required. There is one caregiver on full shifts for the morning, afternoon and night shifts. They are supported by a lodge support person (housekeeper / second caregiver) who works from 8.00 am to 1.00 pm and one from 4.30 pm to 6.30 pm. Interviews with caregivers, one family member and residents confirmed that staffing is adequate to meet the needs of residents. After 6.30 pm to 7.00 am, there is a second person assist, who is within a 20-minute drive, who staff can call on if required.
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 clinical nurse manager reported that prescribed medications are delivered to the facility and checked by her on entry. The service has implemented an electronic medicine management system. The medication area evidenced an appropriate and secure medicine storage area. The medication fridge temperatures were reviewed and recorded weekly. Controlled drugs are stored appropriately, and weekly checks have occurred, and temperatures are within ranges. All staff authorised to administer medicines had current competencies. Medication training was last completed February 2019. The medication round was observed and evidenced appropriate practices were followed. Administration records were maintained in files sampled. All ten medication charts sampled had photo identification, medicine charts were legible and discontinued medicines were dated and signed by the GPs. Warfarin doses were correctly prescribed, allergies were documented. All 'as required' (PRN) medication was identified for individual residents and correctly prescribed, and three-monthly medicine reviews were consistently documented as completed on the electronic system. The previous findings have all been addressed. There were no residents self-administering medicines at the facility.
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	All meals and baking are done in the facility kitchen. There is a food control plan in place expiring on 28 February 2020. There is a rotating seasonal menu that was reviewed by the dietitian in November 2016 and is planned for review in May 2019. All cooking is completed by the kitchen manager and two designated kitchen staff. All three-kitchen staff have completed food safety training. Fridge, dishwasher, freezer and food temperatures are monitored. All dry foods (breakfast cereals) have a date of expiry indicated, and dry food opened is stored in a sealed container in the original packaging. The previous finding has been addressed. All surfaces in the kitchen meet infection control requirements, and cleaning schedules are maintained. The kitchen manager and care staff confirmed they were aware of the residents' individual dietary needs. There were copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the kitchen manager.

		The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	In all files sampled the residents' care plans were personalised to the resident. However, the care plan interventions did not always reflect the assessments and the care required, this is a repeat finding. Short-term care plans were available on the nurse's computer, but not in the resident file for changes in care. In interviews, staff reported they received adequate verbal information for continuity of residents' care. The residents had input into their care planning and review, confirmed at resident and family interviews
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	The residents' care plans sampled, evidenced some interventions based on assessed needs, desired outcomes or goals of the residents (link 1.3.5.2). Monitoring forms identify neurological observations are recorded for all unwitnessed falls and falls with the potential for a head injury, and effectiveness of analgesia is recorded in the progress notes and in the electronic medication charts. These aspects of the previous finding have been addressed. Monitoring for behaviours that challenge are a continued shortfall from the previous audit. The GP documentation and records were current in files sampled. In interviews, residents and one relative confirmed current care and that treatment met their needs. Nursing progress notes and observations are maintained for all monitoring required. Staff interviewed confirmed they were familiar with the current care interventions for the residents. There was a wound assessment plan and evaluation for the one wound, which was reflective of progression and deterioration of the wound for a resident with a chronic wound.
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	PA Moderate	The facility manager is currently completing Careerforce training around diversional therapy and is the lead activities person. There is an activities person who visits the facility and assists the residents with crafts. The residents have been busy stripping lavender grown in the garden and making lavender bags to sell in the community as a fundraiser for resident trips. There are happy hours, and member of staff cares for the residents' nails two hours each week. There is a scheduled movie afternoon on a Thursday, facilitated by a relative/volunteer/board member. Caregivers assist the residents with housie and group games at the weekends. Special events are celebrated, such as baby showers for staff with games that the residents can join in. School children visit the facility and the residents are invited to attend the school production. The priest visits on a three-weekly basis to visit residents, and a minister visits on a two-weekly rotation.

service.		A variety of volunteers visit; the fire brigade visited with the vintage fire engine and took the residents around the village. The vintage car society took the residents for a drive around the lakes. The facility held a fundraiser dinner to purchase electric beds and raised $4,500. There are volunteers available to drive the community car to escort residents to appointments. The Whalan Lodge Trust won the Trust Power award in March 2019 with the story of Whalan Lodge since the trust took over. Interviews with residents, a relative and staff confirmed the activities programme included input from external agencies and supported ordinary unplanned/spontaneous activities including festive occasions and celebrations. Residents' activities attendance records are maintained, however not all residents had an activity care plan and no care plans had been evaluated. The previous audit shortfalls continue to require improvement.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The residents' files reviewed evidenced the residents' care plans were reviewed six monthly and document achievements and progress towards meeting resident goals. Interviews with residents and the relative confirmed their participation in care plan evaluations. The residents' progress notes were written by caregivers at the end of each shift, in all files reviewed. The registered nurse writes progress notes at least weekly, and following incidents. When resident's progress was different than expected, the registered nurse (RN) contacts the GP, as required. Short-term care plans in the resident files were reviewed and resolved. The previous finding has been addressed.
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 and expires on 29 August 2019. There is reactive and preventative maintenance in place. There is a current test and tag programme of electrical equipment and current calibration of clinical/medical equipment. A gas cylinder system has been installed since the last audit. Hot water temperature monitoring is recorded monthly and temperatures are within range. The previous finding has been addressed. There is easy access to all areas, ramps are provided where required. There are communal areas for residents to join other residents and quiet areas for residents and visitors to meet and areas that provide privacy when required. There are outside areas where residents can sit with outside seating and shade provided.
Standard 3.5: Surveillance Surveillance for infection is carried out	FA	The clinical nurse manager is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed on the electronic system, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is

in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		acted upon in a timely manner.
Standard 2.1.1: Restraint minimisation Services 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. On the day of audit, there were no residents requiring restraint or using enablers. Staff receive training around restraint minimisation and the management of challenging behaviours, last occurring in April 2018, restraint training is planned for August 2019.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	The resident files have pre-printed care plans in place Not all interventions were documented to support caregivers on how to care for each resident. Information and changes in condition are handed over in each handover. Caregivers interviewed were knowledgeable of the current individual needs and interventions required for each resident.	(i) Three residents with unintentional weight loss had no interventions documented around this, either in a short-term care plan or the long-term care plan. (ii) One resident on warfarin had no risks or side effects documented in the long-term care plan. (iii) One resident with a chronic wound did not have interventions to support the wound, or risks and reporting associated with a wound documented in the long-	(i)-(iii) Ensure all care plans and short-term care plans are reflective of current resident need. 60 days

			term care plan or a short-term care plan.	
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Monitoring charts are in place for behaviours; however, behaviour monitoring charts and care plans do not identify triggers or a description of the behaviours. Monthly weights and pain monitoring is recorded in the electronic medication charts. Monitoring charts are used to inform the care plan.	Behaviour monitoring charts and care plans do not identify triggers or a description of the behaviours.	Ensure behaviour monitoring forms describe the whole episode of challenging behaviour to aid identification of possible triggers and interventions in the care plan. 90 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Moderate	All residents have an activities assessment completed on admission to the service. Activities records are maintained. The residents interviewed state there are a variety of activities on offer to suit a variety of need and the residents are supported and encouraged to complete activities of their choice. However, activity plans are not all in place and activity plans are not all reviewed 6 monthly. This continues to be a shortfall from the previous audit.	i) Two of five resident files reviewed did not have completed activities care plans. ii) Five of five residents' files did not have activities care plans evaluated at least six monthly.	Ensure all residents have completed care plans and care plans are evaluated at least six monthly. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.