The Whalan Lodge Trust - Whalan Lodge

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 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: 7 May 2018 End date: 7 May 2018

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: 13

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. The facility is governed by a community trust board. On the day of the audit there were 13 residents. Whalan Lodge is managed by a facility manager who has been at the service for six months. She is supported by a part time clinical nurse manager/registered nurse who has worked at Whalan Lodge for ten months and an assistant manager. Family and residents interviewed spoke positively about the care and support provided.

This certification 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, family members, staff and management.

Improvements are required around informing family of incidents, internal audits, the hazard register, human resource documentation, staff training, interventions, monitoring, activities programme, care plan evaluations, medication management, food storage and hot water temperatures.

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.		Some standards applicable to this service partially attained and of low risk.

The staff at Whalan Lodge ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and advocacy services is easily accessible to residents and families. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

Organisational management

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

Whalan Lodge has a documented quality and risk management system. Quality data trends analysis related to incident and accidents, infection control, restraint and complaints are collected. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides

new staff with relevant information for safe work practice. There is an annual in-service training calendar schedule. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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. Care plans are clearly written, and caregivers report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. The residents' files evidenced individual activities were provided either as a group 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.

There is a kitchen and on-site staff that provide the food service. Residents spoke positively about the 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.		Some standards applicable to this service partially attained and of low risk.

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

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged to allow residents to mobilise.

There is a designated laundry, which includes storage of cleaning and laundry chemicals. There are emergency procedures in place and the service has sufficient supplies for use in an emergency. 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. Smoking is only permitted in a designated external area.

A civil defence/emergency plan is documented for the service. There is a first aid trained staff member on duty at all times.

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. On the day of audit there were no residents using any restraints or enablers. Staff receive training around restraint minimisation and the management of challenging behaviours.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. 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	35	0	4	6	0	0
Criteria	0	81	0	7	5	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with four care staff (one clinical nurse manager, registered nurse (RN), one caregiver, one carer support and one cook) confirmed their familiarity with the Code (link 1.2.7.5). Seven residents and three family members interviewed confirmed the services being provided are in line with the Code.
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	There are established informed consent policies/procedures and advanced directives. General written consents are obtained on admission. Specific consents are obtained for specific procedures such as influenza vaccine. All five resident files contained signed general consents. Resuscitation status had been signed appropriately. Advance directives were signed for separately identifying the resident's wishes for end of life care. An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers (CG) interviewed demonstrated a good understanding in

		relation to informed consent and informed consent processes. Three family and seven residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. All five resident files reviewed had signed admission agreements.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service reception area. The information identifies who the resident can contact to access advocacy services. Staff interviewed were aware of the right for advocacy and how to access and provide advocate information to residents if needed (link 1.2.7.5). Residents and family members that were interviewed were aware of their access to advocacy services.
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 and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.
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. No complaints have been received since the previous audit. A complaints procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and advocacy pamphlets are located at the main entrance of the service. On admission a manager discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code.

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	Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy in place, however training has not been provided to staff in the last 2 years (link 1.2.7.5).
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	The service has guidelines for the provision of culturally safe services for Māori residents. There is a Māori health plan. On the day of the audit there were no residents that identified as Māori. Discussions with staff confirmed that they are aware of the need to respond with appropriate cultural safety (link 1.2.7.5).
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	Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Family members reported that they feel they are consulted and kept informed and family involvement is encouraged.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service meets the individualised needs of residents with needs relating to rest home level care. The quality and risk management system has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training (link 1.2.7.5). The

		facility manager and clinical nurse manager/RN share the responsibility for coordinating the internal audit programme. Monthly staff/quality meetings and four-monthly residents' meetings are conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed stated that they feel supported by the facility manager, clinical nurse manager/RN and care staff.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Information is provided in formats suitable for the resident and their family. Residents and relatives interviewed confirmed that the staff and management are approachable and available. Ten accident/incident forms reviewed identified that family were not always notified following a resident incident. Families are invited to attend the four-monthly resident/relative meetings. Interpreter services are available as required.
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 seven board members. Whalan Lodge is a 14-bed rest home. On the day of the audit, there were 12 residents under the aged related residential care (ARRC) contract and one resident under a palliative care contract. The Whalan Lodge facility manager has been in the position since September 2017. She has a background in hospitality and human resources management. 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/RN who has been in the role for 10 months. 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. The facility manager has completed eight hours of professional development in relation to managing a rest home.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective	FA	The facility manager reported that in the event of her temporary absence the assistant manager fills the role with support from the RNs and other care staff.

manner which ensures the provision of timely, appropriate, and safe services to consumers.		
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.	PA Moderate	Whalan Lodge has a documented 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. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. 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. Staff interviewed confirmed they are made aware of new/reviewed policies. Quality data analysis related to incident and accidents, infection control, restraint and complaints are collected. 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, however not all internal audits for 2017 and 2018 had been completed as per the required schedule. Corrective actions required for internal audits that are not compliant have not been fully completed or signed off. 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 meeting. Hazard identification forms are completed for any accidents or near misses, however there was no documented hazard register in place. The resident/relative satisfaction survey was completed in June 2017, all residents/relatives surveyed were satisfied with the quality of the service being provided. 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	There is an accident/incident reporting policy that includes definitions and outlines responsibilities. Ten accident/incident forms were reviewed for March and April 2018. All document timely RN review and follow-up, however neurological observations were not fully completed for two resident falls that resulted in a potential head injury (link 1.3.6.1). Ten of ten incident forms did not have documented evidence of notification to next of kin (link 1.1.9.1). 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.	PA Moderate	There are human resources policies to support recruitment practices. Five staff files reviewed (one facility manager, one clinical nurse manager/RN, one caregiver, one carer support and one cook) included evidence of the recruitment process including police vetting, signed employment contracts and job descriptions. Missing was evidence of completed orientation checklists, annual performance and appraisals reference checks. A current practising certificate was sighted for the clinical nurse manager/RN. The two RNs have completed interRAI training. The service has an orientation programme in place to provide new staff with relevant information for safe work practice. There is an annual in-service training calendar schedule, however there was no documented evidence of eight hours annual training being completed for all staff in 2017. Discussion with the caregivers confirmed that monthly in-service training was not completed in 2017.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Staff rostering, and skill mix policy is in place. Staff are rostered on to manage the care requirements for the 13 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 call duty with support from a designated RN as required. There is one caregiver on full shifts for the morning, afternoon and night shifts. They are supported by a carer support who works from 7.00 am to 1.30 pm and one from 4.00 pm to 7.00 pm. Interviews with caregivers, relatives and residents confirm that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements.
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	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs are provided for families and residents prior to admission. Admission agreements reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement.

identified.		
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There was appropriate communication between families and other providers in the residents' files that demonstrated transition, exit, discharge or transfer plans were communicated, when required. Transition, exit, discharge, or transfer form/letters/plan were located in residents' files sampled, where this was 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.	PA Moderate	The clinical nurse manager reported that prescribed medications were delivered to the facility and checked by her on entry. The medication area evidenced an appropriate and secure medicine storage and dispensing system. The medication fridge temperatures were not reviewed or recorded. Controlled drugs are stored appropriately but weekly checks have not occurred. All staff authorised to administer medicines had current competencies. Medication training was last completed January 2017. The medication round was observed and evidenced appropriate practices were followed. Administration records were maintained in files sampled. All administration charts corresponded with prescriptions. Specimen signatures are documented. All ten medication charts sampled had photo identification, medicine charts were legible and discontinued medicines were dated and signed by the GPs. However, 'as required' (PRN) medication was identified for individual residents but not always correctly prescribed, and three-monthly medicine reviews were not consistently documented as completed The residents' medicine charts recorded all medications a resident was taking (including name, dose, frequency and route to be given), but not every medication had an individual signature and not every chart had allergies documented. One resident was having warfarin administered but prescribing practices did not meet medication guidelines. 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.	PA Low	The food service policies and procedures are appropriate to the service setting. There is a rotating seasonal menu that was reviewed by the dietitian in November 2016. The cooking is completed by the kitchen manager, volunteers and care staff. The kitchen manager has completed food safety training. There is evidence the staff have read the food service policies and procedures. Fridge, dishwasher, freezer and food temperatures are monitored. Not all dry food is stored appropriately. All surfaces in the kitchen meet infection control requirements. In interviews, 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 1.3.2: 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	A process to inform potential residents and family, in an appropriate manner, of the reasons why the service had been declined would be implemented, if required. The potential residents would be declined entry if not within the scope of the service or if a bed was not available. The resident would be referred back to the referring service as reported by the facility manager.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files reviewed identified the residents' needs, outcomes and goals were identified via the assessment process and recorded in files sampled. The facility has processes in place to seek information from a range of sources. All residents had current interRAI assessments and care plans addressed some identified needs (link 1.3.5.2). In interviews, residents and family confirmed their involvement in assessments.
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 reflect the residents ADL's. However, the care plan interventions did not always reflect the assessments and the level of care required. Short-term care plans were available and used for acute changes in care. They were signed off by the RN when problems were resolved in files sampled with a short-term care plan. In interviews, staff reported they received adequate 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	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). The GP documentation and records were current in files sampled. In interviews, residents and family confirmed their and their relatives' current care and that treatment met their needs. Nursing progress notes and observations charts are not maintained for all monitoring required. Interviewed staff confirmed they were familiar with the current interventions of the resident they were allocated.

outcomes.		Wound care management, treatment and review is based on documented assessment findings. This was evident in the files reviewed of three residents with current wounds.
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.	PA Moderate	At the time of the audit the service had not had a staff member specifically employed to provide activities for several months. A variety of volunteers visit, but these are not always regular. Interviews with residents, family and staff confirmed the activities programme included input from external agencies and supported ordinary unplanned/spontaneous activities including festive occasions and celebrations. There were current, individualised activities assessments and care plans in three of five residents' files. These were not reviewed six monthly. The residents' activities attendance records are maintained.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Timeframes in relation to care planning evaluations are documented. The residents' files evidenced the residents' care plans were up-to-date and reviewed six monthly but did not consistently record the degree of achievement to the intervention provided and progress towards meeting the desired outcomes. In interviews, residents and family confirmed their participation in care plan evaluations. The residents' progress records were entered on each shift in each file sampled. When resident's progress was different than expected, the registered nurse (RN) contacts the GP, as required. Short-term care plans were in some of the residents' files, used when required.
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	Appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services. This included referrals to DHB specialists in files sampled. Family communication sheets confirmed family involvement.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as	FA	Documented processes for the management of waste and hazardous substances are in place. All chemicals were labelled with manufacturer labels. There is a designated area for storage of cleaning/laundry chemicals and they are stored securely. Material safety datasheets and product user charts are available and accessible for staff. Staff receive training and education to ensure

a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		safe and appropriate handling of waste and hazardous substances. There was provision and availability of protective clothing and equipment that was appropriate to the recognised risks, and used by staff. Interviews with caregivers confirmed management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	A current building warrant of fitness is displayed and expires on 26 August 2018. 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. Interviews with staff and observation of the facility confirmed there was adequate equipment. Hot water temperature monitoring has not been conducted or recorded. There are quiet areas at the facility 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. Floor surfaces are appropriate, corridors allow residents to pass each other safely and there is sufficient space to allow the safe use of mobility equipment. Hand rails are appropriately located in the hallways.
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	There are adequate numbers of accessible toilets/bathing facilities located at the facility. Visitors' toilet and communal toilets are conveniently located and have a system that indicates if it is engaged or vacant. Residents and family interviewed, reported that there are sufficient toilets and showers. Fixtures, fittings, and floor and wall surfaces are of accepted material for cleaning purposes. Alcohol hand cleaners were available throughout the facility and at the front door for visitors.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas	FA	There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Rooms are personalised. Hallways and communal areas allow wheelchair access.

appropriate to the consumer group and setting.		
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	There is a dining room, lounge and balcony for residents use with appropriate setting arranged. Residents are able to mobilise freely in these areas. Residents are able to access areas for privacy, if required. The lounge area was able to be used for activities.
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	There are policies and procedures for management of laundry and cleaning practices. The caregivers are responsible for the laundry. Residents and family members confirmed satisfaction with laundry and cleaning services. The sluice is in the laundry. There is a designated area for the secure storage of cleaning and laundry chemicals. Laundry and cleaning processes are monitored for effectiveness via the internal audit programme (link 1.2.3.6).
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency/disaster management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation drills are completed with the last fire evacuation drill occurring on 19 April 2018. There is a civil defence kit and pandemic/outbreak supplies available in the facility that are checked six monthly. Fire training and security situations are part of the orientation for new staff. There are adequate supplies in the event of a civil defence emergency including dry sufficient food, water, blankets and alternate gas cooking (BBQ and gas hobs in the kitchen). Short-term back-up power (battery bank) for four hours emergency lighting is in place. There is a first aid trained staff member on duty 24/7. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.
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	FA	Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Night stores are appropriately placed for warmth of the facility, heat pumps are available in lounge areas and the resident bedrooms have a heater available. The service also has wood burners. Family and residents interviewed confirmed the facilities were maintained at an appropriate temperature. There is a designated external smoking area.

comfortable temperature.		
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	Whalan Lodge has an established infection control (IC) programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical nurse manager is the designated infection control nurse with support from the assistant manager and staff (infection control team). Minutes are available for staff. Audits have been conducted (link 1.2.3.6) and include hand hygiene and infection control practices. Education is provided for new staff on orientation and annually (link 1.2.7.4 and 1.2.7.5). The infection control programme was last reviewed in January 2017.
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 clinical nurse manager at Whalan Lodge is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
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	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by an external provider and have been reviewed and updated annually.
Standard 3.4: Education The organisation provides relevant	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has not always occurred (12.7.5). The nurse manager has completed infection control training. Visitors are advised of any outbreaks of infection

education on infection control to all service providers, support staff, and consumers.		and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
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	Infection surveillance is an integral part of the infection control programme and is described in Whalan Lodge's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, 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 infection control meetings, and monthly staff meetings. If there is an emergent issue, it is 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, the service had no residents using any restraints or enablers. Staff receive training around restraint minimisation and the management of challenging behaviours, last occurring in April 2018.

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 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	There is an accidents and incidents reporting policy. Ten accident/incident forms were reviewed. Ten of ten incident forms did not have documented evidence of notification to next of kin/family.	Ten accident/incident forms were reviewed in total. Ten of ten incident forms did not have documented evidence of notification to next of kin.	Ensure that documentation reflects that next of kin are notified of any resident incidents/accidents. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There is an annual internal audit calendar in place, however not all internal audits for 2017 and 2018 had been completed as per the required schedule.	i) There was no documented evidence of internal audits being completed as per the required schedule for 34 of 44 internal audits for 2017 and 10 of 21 audits for 2018 year-to-date.	i) Ensure that all internal audits are completed as per the required schedule. ii) Ensure that corrective actions required for internal

			ii) Corrective actions required for internal audits that are not compliant, have not been fully completed or signed off.	audits that are not compliant, are fully completed and signed off. 90 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Moderate	There is a health and safety and risk management system in place including policies to guide practice. Hazard identification forms are completed for any accidents or near misses, however a current documented hazard register could not be located.	A documented hazard register for the facility that includes identified on-going hazards and new hazards could not be located.	Ensure that there is a documented hazard register in place and this is reviewed regularly. 90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Recruitment policy and procedures describes the appointment process. Five staff files selected for review included evidence of the recruitment process including police vetting, signed employment contracts and job descriptions. Missing was evidence of completed orientation checklists, annual performance appraisals and reference checks.	Five staff files were reviewed, four of five files did not have documented evidence of completed orientation checklists, two of five did not include an up-to-date annual performance appraisal and four of five did not have reference checks completed.	Ensure that all staff files include completed orientation checklists, annual performance appraisals and reference checks. 90 days

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	There is an annual in-service training calendar schedule, however there was no documented evidence of eight hours annual training being completed for all staff in 2017. Discussion with the caregivers confirmed that monthly in-service training was not completed in 2017.	i) There was no documented evidence of eight hours annual training being completed for all staff in 2017. ii) Not all compulsory education has been completed within the required two-year period. Education not completed includes; abuse and neglect, cultural safety, code of rights, sexuality/intimacy, spirituality/counselling, complaints/open disclosure, nutrition/hydration, and privacy/dignity.	i) Ensure that there is eight hours annual training being completed for all staff. ii) Ensure that the annual education planner is fully implemented, and education is provided to cover all contractual and legal requirements. 90 days
Criterion 1.3.12.1 A 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	Medication is delivered and checked by the clinical nurse manager on arrival. A blister pack storage is used. All medications are stored safely except that the fridge temperatures are not recorded, and control drug documentation does not meet requirements. Medication processes do not align with required legislation and guidelines.	i) Medication fridge temperatures are not documented as reviewed. ii) Weekly controlled drug checks are not documented as occurring. iii) For six of ten medication files sampled, GP three monthly reviews had not been documented as completed.	i) Ensure medication fridge temperatures are taken and recorded regularly. ii) Ensure weekly controlled drug checks occur. iii) Ensure three monthly GP medication reviews occur and are documented. iv) Ensure each

			iv) The prescription on four of ten medication charts sampled had one signature and a bracket to imply the signature applied to all dates and/or medicines prescribed. v) Four of ten medication charts did not have indications for use documented for 'as required' medications. vi) Allergies were not documented on three of ten medication charts sampled. vii)The warfarin dosage is a verbal instruction given by the practice nurse to a staff member on duty who documents the dose to be administered and the INR on a form. There was no doctor's signature.	medication on a chart has an individual signature and date. v) Ensure indications for use are documented by the prescriber for all 'as required' medications. vi) Ensure allergies are documented for every resident. vii) Ensure warfarin is managed safely and a doctor signs for each changed prescription. 30 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	The kitchen was observed to be clean and tidy. Staff conduct kitchen cleaning and sign off when this is completed. Interview with the cook confirmed they have conducted food safety training.	Opened dry goods and cereals were not stored in sealed containers. Decanted food was not dated.	Ensure that food storage complies with legislation. 90 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	All five resident files had a long-term care plan that addressed some of each resident's identified issues.	Five of five resident files sampled did not document interventions for all identified needs. Examples included diabetes management, UTI, warfarin management, pain management behaviour and falls management.	Ensure care plans have documented interventions for all identified needs. 60 days
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	Resident needs are partially documented in care plans (link 1.3.5.2). There was evidence of monitoring of weights, bowel charts and pulse and blood pressure. Behaviour monitoring of one resident had not occurred and neuro observations for two residents with potential head injuries had not been completed. Residents on pain relief for acute pain did not have the effectiveness of the given pain-relief medication documented	i) Three of five resident files sampled did not have the effectiveness of 'as required' pain relief documented. ii) One resident that has behaviours that challenge did not have any behaviour monitoring and two residents with a potential knock to the head did not have neuro observations taken.	i) Ensure the effectiveness of 'as required' medications are documented. ii) Ensure that residents with challenging behaviours have these monitored and a potential hit to the head have neuro observations taken. 60 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	PA Moderate	At the time of the audit the service had an activities programme that was provided by volunteers. There was no staff member delegated to oversee the activities, and interviews	(i) There is no staff member designated to provide activities and interviews with residents and families indicated	(i) Ensure staff with hours dedicated to activities develop and implement an

consumer.		reported that volunteers are sometimes unable to meet the schedule requirements. Not all residents had activities assessments and plans and not all plans had been reviewed.	neutrality or discontent with the activities programme. (ii) Two of five resident files sampled did not have an activities assessment or plan documented. (iii) Three of three residents with activities plans had not had these reviewed for more than 12 months.	activity plan that meets the needs and interests of the residents. (ii) – (iii) Ensure all residents have an activities assessment and plan and this is reviewed at least 6-monthly with the care plan review 60 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Care plan evaluations are conducted six monthly, however the evaluations did not always record the degree of achievement towards meeting the residents' desired outcomes.	Five of five care plan evaluations do not consistently record the degree of achievement to the intervention provided and progress towards meeting the desired outcomes.	Ensure care plan evaluations did not document progress toward goals. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The service has routinely undertaken testing and tagging of electrical equipment and has had all medical equipment serviced and/or calibrated. Not water temperature monitoring has not been completed.	There was no evidence of monitoring or recording of hot water temperatures.	Ensure hot water temperatures are monitored and recorded regularly. 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.

No data to display

End of the report.