Geraldine Retirement Village 2009 Limited - Geraldine Retirement Village

Introduction

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

The audit has been conducted by 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:	Geraldine Retirement Village (2009) Limited
Premises audited:	Geraldine Retirement Village
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 January 2019 End date: 23 January 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:	10

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

Geraldine Retirement Village is privately owned and managed. The owner/manager has been in the role for nine years. Geraldine Retirement Village is certified to provide rest home level care for up to 20 residents. On the day of audit, there were 10 residents. The owner/manager is supported by one registered nurse/clinical manager and care staff. Residents and family interviewed spoke positively about the care and support provided.

Geraldine Retirement Village has a business quality and risk management plan. Goals and objectives of the business are identified and reviewed annually.

This unannounced surveillance audit was conducted against the relevant Health and Disability Standards and contract with the district health board. The audit processes included the review of policies and procedures, the review of staff and resident's files, observations and interviews with residents, relatives, management, general practitioner and staff.

This audit identified the service continues to fully meet the standards included as part of this audit.

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.

Geraldine Retirement Village provides care in a way that focuses on the individual resident. Open disclosure principles are implemented. Complaints processes are communicated to residents and families and the complaint register is up to date. Complaints management system complies with the Code. Residents and family interviewed verified ongoing involvement with community.

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.

Geraldine Retirement Village is implementing a quality and risk management system that supports the provision of clinical care. Quality data is gathered around infection control, internal audits, concerns and complaints and surveys. An annual review of the quality programme and incident and accidents reports is completed, and the outcome communicated to staff.

Health and safety policies and procedures are implemented. The hazards and risk register had been reviewed in 2018. Health and safety issues are discussed both at staff and quality meetings. There are procedures to guide staff in managing clinical and non-clinical emergencies and a registered nurse is on call at all times.

Annual resident and relative surveys are conducted annually with the most recent during 2018. Corrective actions and quality improvements have been implemented and communicated to families.

There are human resources management processes in place and annual performance appraisals are completed. New staff receive an orientation programme prior to their commencement of care to residents. A staff education programme is implemented.

Staffing levels and skill mix are appropriate for the service level to provide safe service delivery.

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.		Standards applicable to this service fully attained.

The registered nurse/clinical manager is responsible for managing entry to the service. All initial assessments, risk assessments, interRAI and long-term care plans are developed and evaluated by the registered nurse/ clinical manager within the required timeframes. Residents and relatives interviewed confirmed they were involved in the care planning and review process.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting with a focus on community involvement and maintaining residents' past and present interests.

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed.

Meals are prepared on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

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.

The building has a current warrant of fitness. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are utilised for group and individual activities. Outdoor areas are safe and accessible for the rest home residents and shade is provided. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely.

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.

Restraint minimisation is practiced and overseen by the clinical manager. There are no residents using restraint or enablers. Staff have completed training around restraint minimisation and managing behaviours that challenge.

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 infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to staff.

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	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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	Complaints management system complies with the Code. A complaints register is maintained and there were no documented complaints in 2017 and four in 2018. All four complaints in 2018 were reviewed. Each complaint included appropriate and timely responses. The complaint process is discussed with the residents and their families at the time of entry to the home. Residents and families interviewed confirm they are aware of who to make a complaint to if required. Staff have training on advocacy and complaints management. Complaint forms are visible and available for residents and relatives.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Ten incidents/accidents forms were reviewed. The forms include a section to record family notification. All forms reviewed document that family have been informed. A resident satisfaction survey was undertaken during 2018, corrective actions were discussed at the resident meeting. Five residents and two family interviewed confirm open disclosure principles are implemented. Family are consulted and informed of incidents and accidents or a change in care provision. Education on open disclosure, consumer rights and communication is provided. Staff confirm their understanding of open disclosure. Communication with relatives is documented in the residents' files. Interpreter services are available and offered to residents with English as a second language.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Geraldine Retirement Village business is owned by four business partners, with one couple providing day-to-day management of the service. The business partners purchased the home in 2009. The two owners have rolls at Geraldine. One is the manager (3 days a week) and the other oversees maintenance. The service employs one registered nurse/clinical manager. Geraldine Retirement Village is certified to provide rest home level care for up to 20 residents within a 10-bed rest home and 10 serviced apartments. There were ten rest home residents on the day of audit (eight in the rest home and two in the serviced apartments). One resident is under a mental health contract, all other residents are under the ARC contract. There were no respite residents. The Geraldine Retirement Village has a business quality and risk management plan. Goals and objectives of the business are identified and reviewed annually. The manager and clinical manager has maintained at least eight hours of professional development in the past twelve months.
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	The Geraldine Retirement Village continues to implement its quality and risk management system. An annual review of the quality programme and incidents and accidents has been completed and outcomes of these have been communicated to staff. Discussions with staff (clinical manager, three caregivers, one activities coordinator and one cook) and review of meeting minutes, demonstrates staff involvement in quality and risk activities. Key components of service delivery are linked to the quality and risk management system. The internal audit programme is implemented. If an audit identifies shortfalls, required corrective actions are implemented and are signed off in a timely manner. A monthly summary of internal audit outcomes is provided to the staff through staff meetings for discussion. The service collates accident/incident, health and safety and infection control data. Monthly comparisons, trends, graphs and benchmarking data are displayed for staff information. A resident survey was completed in 2018 with a 90% satisfaction rate. The outcome of the survey has been fed back to participants and staff as evidenced in meeting minutes. Health and safety policies and procedures are implemented. The hazards and risk register has been reviewed in 2018. Health and safety issues are discussed at the staff and quality meetings. There are procedures to guide staff in managing clinical and non-clinical emergencies and the clinical manager is on call at all times.

		Staff interviewed were familiar with health and safety matters. Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Corrective actions around falls prevention have been implemented.
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 from December 2018 and January 2019 were sampled. Incident forms reviewed evidenced that appropriate clinical care was provided to residents in a timely manner. Reports reviewed include a description of the incident, immediate care and follow up and any investigations conducted by the registered nurse. Neurological observations have been fully conducted for all unwitnessed falls. Accidents/incidents were recorded in the resident's progress notes and changes made to care plan documentation as needed. There is documented evidence the family had been notified promptly of accidents/incidents. Relatives interviewed confirm they are promptly notified of all incidents. Discussions with the manager confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. A section 31 notification was sent in 2018 for a medication error.
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	There are human resources policies to support recruitment practices. Five staff files sampled (two caregivers, one cook, one activities coordinator and the clinical manager) contained all relevant employment documentation. Current practising certificates were sighted for the clinical manager who is interRAI trained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment and staff files reviewed evidenced completed employment documentation. Annual performance appraisals are completed. There is an education planner in place that covers education requirements. The programme provided is comprehensive and covers compulsory and contractual training requirements. Care staff complete competencies relevant to their role including medication competencies.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe	FA	Staffing roster provides sufficient staffing covering for the provision of care and service to residents. There is a clinical manager who works 30 hours a week and covers on call. The owner/manager is onsite three days a week. The manager is on call for non-clinical matters. Staffing are rostered as follows: AM – one long shift from 0900-1530 and one from 0700 - 1100; PM- one long

service from suitably qualified/skilled and/or experienced service providers.		shift from 1530- 2300 and short shift 1700-1900; and night- one caregiver. The cook works 0700-1300 and a cleaner works 0930-1330. Three caregivers, four residents and two relatives interviewed confirmed that sufficient staff are rostered for each shift. Staff interviewed state shifts are extended in times of resident need.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely. Medication administration practice complies with the medication management policy for the medication round sighted. There was evidence of three-monthly reviews by the GP. Registered nurses and medication competent caregivers administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a blister packed medication management system for the packaging of all tablets. The clinical manager reconciles the delivery and documents this. There were no residents self-administering medication on the day of audit.
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 are prepared and cooked at Geraldine Retirement Village. There is a four-weekly summer and winter menu which has been recently reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. All food preferences are met. Staff were observed assisting residents with their meals and drinks. Supplements and smoothies are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge and freezer temperatures are recorded daily and recorded. End cooked food temperatures and food temperatures prior to the food being served to the residents are recorded. All food services staff have completed food safety and hygiene and chemical safety.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and	FA	When a resident's condition alters, the clinical manager initiates a review and, if required, GP consultation. The relatives interviewed confirm they are notified of any changes to their relative's health including (but not limited to): accident/incidents, infections, health professional visits and changes in medications. In the residents' files reviewed, short-term care plans have been commenced with a change in heath condition and linked to the long-term care plan. The interRAI assessment, and risk assessments informs the development of the care plan.

desired outcomes.		Continence products are available. Resident files include a urinary continence assessment, bowel management and continence products identified. Specialist nursing advice is available from the DHB as needed. Wound assessments, treatment and evaluation plans were in place for one resident with a wound (skin tear). There were no residents with pressure injuries. All wounds have been reviewed in appropriate timeframes. Assessments include oral assessment, pain, manual handling, continence, pressure, and falls. Weights are recorded at least monthly.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service employs an activities assistant who works 15 hours per week. The weekend programme is delivered by care staff and volunteers. The activity programme is planned around meaningful everyday activities such as gardening, baking, folding laundry and shopping trips. The programme includes walking groups and exercises. There are weekly van rides and church services, group and individual activities of the residents' choice. There is evidence that the residents have input into review of the programme via the resident survey and meetings. This feedback is considered in the development of the resident's activity programme. The activity programme is developed monthly. An activity profile is completed on admission in consultation with the resident and relatives (as appropriate). The activities documentation in the resident files sampled reflected the interests of each resident. Residents interviewed evidenced that the activity programme had a focus on maintaining independence. In the files reviewed the recreational plans had been reviewed six-monthly.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The clinical manager evaluates all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status. There was at least a three-monthly review by the GP. All changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the care plan has been amended.
Standard 1.4.2: Facility Specifications Consumers are provided	FA	The facility has a current building warrant of fitness which expires on 1 June 2019. The physical environment allows easy access, movement for the residents and promotes independence for residents with mobility aids. The part-time maintenance person (owner) carries out maintenance requests and records corrective actions in the maintenance book. Monthly internal building and external building maintenance schedules are in place.

with an appropriate, accessible physical environment and facilities that are fit for their purpose.		Water temperature monitoring of different rooms is carried out each month (sighted) and complies with regulations. The grounds are tidy, well maintained and able to be accessed safely. There are outdoor ramps with handrails, outdoor seating, shaded areas and raised garden beds. There is a designated outdoor smoking area.
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	The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control, handwashing and cleaning internal audits and education have been completed. Infection rates have been low. Trends are identified, and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. There have been no outbreaks since the previous audit. Outbreak management was discussed with the clinical manager who is up to date with current expectations from the Public Health Authorities. Staff receive ongoing training and support and the registered nurse/ clinical manager ensures that infections are prevented and managed both for staff and residents. Visitors are encouraged to not visit when they are unwell and to use hand sanitiser.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint minimisation is practiced. The clinical manager oversees the restraint process within the facility. There are policies around restraint, enablers and the management of residents who may exhibit behaviours that challenge. The service remains restraint-free and has no residents using enablers or restraints. Advised that any resident requiring restraint or who exhibited behaviours that may challenge, would be reassessed to determine their suitability to continue to reside in the rest home.

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.

No data to display

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.