

Park Lane Retirement Village Limited - Park Lane lifecare

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:	Park Lane Retirement Village Limited
Premises audited:	Park Lane Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 January 2019 End date: 21 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:	53

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
Yellow	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
Red	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

Park Lane Lifecare provides hospital and rest home level care for up to 87 residents. On the day of audit there were 53 residents. The service is managed by an experienced village manager who is supported by a clinical manager and clinical lead. The residents and family member interviewed spoke positively about the care and support provided.

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

The service continues to implement a comprehensive quality and risk management system. Interviews with staff and review of meeting minutes demonstrate a culture of quality improvements.

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.
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Communication with residents and families is appropriately managed. Families are regularly updated of residents' condition including any acute changes or incidents. Residents and family member interviewed verified ongoing involvement with the community. Complaints processes are implemented and managed in line with the Code.

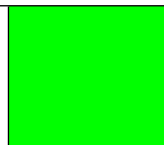
Organisational management

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.
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There are annual quality goals for the service that are regularly reviewed. There is a documented quality and risk management system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents and accidents are reported and appropriately managed. Residents and relatives are provided the opportunity to feedback on service delivery issues at three-monthly resident meetings and via annual satisfaction surveys. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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.

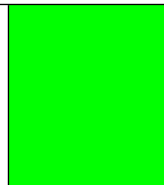


Standards applicable to this service fully attained.

The registered nurses are responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whānau. The activity programme is varied and appropriate to the level of abilities of the residents. Medications are appropriately managed, stored, and administered with supporting documentation. Medication training and competencies are completed by all staff responsible for administering medicines. Food is prepared on-site with individual food preferences, dislikes and dietary requirements assessed by the registered nurses and a dietitian.

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 service has a current building warrant of fitness. There is adequate room for residents to move freely about the home using mobility aids. Outdoor areas are safe and accessible for the 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.

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.
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The service has policies and procedures to ensure that restraint is a last resort. On the day of the audit there were no residents with any restraints and one resident using an enabler. Staff receives training in restraint minimisation.

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.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. 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. The service benchmarks infection control data against other villages within the group.

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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. One complaint (in 2018) has been made at Park Lane Lifecare since the last audit. The complaint reviewed has been managed appropriately with acknowledgement, investigation and response recorded. Residents and the family member interviewed advised that they are aware of the complaints procedure and how to access forms. The village manager has a weekly meeting with residents to discuss any concerns that they may have.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive</p>	FA	<p>Six residents (three rest home, including one in the serviced apartments and three hospital) interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incident/accidents had documented evidence of family notification or noted if family did not wish to be informed. One family member (rest home) interviewed confirmed that they are notified of any changes in their family member's health status. Interpreter services are available as required.</p>

to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The service provides care for up to 87 residents in total (42 residents in dual-purpose rooms in the care centre and 45 serviced apartments certified for rest home level care). On the day of the audit there were 53 residents in total, including 28 rest home residents and 13 hospital residents in the care centre, and 12 rest home residents in the serviced apartments. There were no residents on respite care. All residents were under the aged related residential care (ARRC) agreement.</p> <p>The village manager has been in the role for three and a half years and has experience in the aged care industry and held roles including administration and human resource manager in aged care facilities. A clinical manager was appointed in August 2018 and is an experienced registered nurse (RN) with over 16 years' experience in the aged care industry. The clinical manager is supported by an experienced clinical lead who has been in the position for two years.</p> <p>The village manager provides a monthly report to the Arvida CEO on a variety of operational issues. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Park Lane Lifecare has a business plan 2018/2019 and a quality and risk management programme.</p> <p>The village manager and clinical manager has completed in excess of eight hours of professional development in the past twelve months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a quality and risk management system in place at Park Lane Lifecare which is designed to monitor contractual and standards compliance. There is a 2018/2019 business/strategic plan that includes quality goals and risk management plans for Park Lane Lifecare. The quality and risk management system supports improved resident outcomes and identifies areas of improvement. The village manager and clinical manager are responsible for providing oversight of the quality and risk management system on-site, which is also monitored at organisational level. Interviews with staff confirmed that there is discussion about quality data at various facility meetings. Arvida Group policies are reviewed at least every two years across the group. Head office sends out new/updated policies for staff to read.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. All staff interviewed could describe the quality programme corrective action process. Restraint and enabler use (when used) is reported within the bi-monthly quality improvement and three-monthly clinical/RN meetings. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The March 2018 resident/relative satisfaction survey overall result shows 100% satisfaction with services provided. There were no improvement areas required from the survey. Resident/family meetings occur</p>

		<p>three-monthly and the results of the satisfaction survey have been discussed at the meeting.</p> <p>The service has a health and safety management system that is regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the Health and Safety committee at the monthly meeting. The village manager is part of the Health and Safety committee and has completed specific health and safety training in her role. Hazard identification forms and an up-to-date hazard register is in place which was last reviewed in October 2018. Falls prevention strategies are implemented including identifying residents at higher risk of falling and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. An RN conducts clinical follow up of residents. Ten incident forms reviewed for December 2018 demonstrated that appropriate clinical follow up and investigation occurred following incidents. Neurological observation forms were documented and completed for five reviewed unwitnessed falls or potential head injuries. Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 incident notification required since the last audit. The notification was to confirm the appointment of the new clinical manager in August 2018. An outbreak (respiratory) was notified to the public health authorities in July 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of</p>	FA	<p>There are human resource management policies in place. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. Five staff files were reviewed (one clinical manager, one clinical lead (RN), two caregivers and one diversional therapist). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all five staff files reviewed. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme.</p> <p>The in-service education programme for 2018 has been completed and the plan for 2019 is being implemented. Discussions with the caregivers and RNs confirmed that Altura online training is available and implemented by staff. The eight hours of staff development or in-service education has been provided annually. There are nine RNs and eight have completed interRAI training and one is in progress of completing. The village manager,</p>

legislation.		clinical manager and RNs are able to attend external training, including sessions provided by the district health board (DHB). Arvida Group hosts two conferences per year for village managers and clinical managers to promote the updating of skills and knowledge.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Park Lane Lifecare has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The service has a total of 63 staff in various roles. Staffing rosters were sighted and there is staff on duty to meet the resident needs. The village manager and clinical manager work 40 hours per week and are available on call after-hours for any operational and clinical concerns respectively. There is at least one RN on duty at all times. The RN on each shift is aware that extra staff can be called on for increased resident requirements. There are dedicated housekeeping and laundry staff. Interviews with staff, residents and family member confirm there are sufficient staff to meet the needs of residents.</p> <p>The service has 28 rest home residents and 13 hospital residents in the care centre. There is a clinical lead (RN) on the morning shift who is supported by a RN rostered on the morning, afternoon and night shifts. The RNs are supported by seven caregivers (three long and four short shifts) on the morning shift, five caregivers (two long and three short shifts) on the afternoon shift and two caregivers on at night.</p> <p>In the serviced apartments there are 12 rest home residents. There is an RN or EN rostered on the morning shift who is supported by three caregivers (one long and two short shifts) rostered in the morning and two caregivers (one long and one short shift) in the afternoon. One of the care centre night caregiver's covers the serviced apartment residents. The care centre RN covers the afternoon and night shifts in the serviced apartments.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Ten medication charts were reviewed (five hospital, three rest home and two serviced apartments rest home level). There are policies and procedures in place which comply with current legislation. Medicines are stored in accordance with legislation and current guidelines. Medicine administration practice complies with the medicine management policy in the medicine round observed. RNS, ENs and medicine competent caregivers administer medications and complete medicine competency and medication management education annually. Medications are prescribed on the paper-based medicine management system in accordance with legislative prescribing requirements for all regular, short course and 'as required' medicines.</p> <p>The GPs review the medication charts at least three-monthly. A review of medication signing sheets evidenced that administration of all medications aligned with the medication charts. There were four residents self-administering medications on the day of the audit. All four residents have a medication competency which has been signed and reviewed by the GP, with a copy in the medication file and on the electronic resident file system. All competencies are reviewed on a three-monthly basis. Standing orders are in place and are reviewed by the GP in an annual basis.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a food control plan in place which expires 14 June 2019. There is a food services policy and procedure manual. All food is cooked on-site. The service employs three qualified cooks. The cooks are supported by morning and afternoon kitchenhands. Food services staff have attended food safety and chemical safety training. Cultural preferences and special diets are met. The kitchen receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated with alternatives available. Special diets are accommodated including gluten free, vegetarian, food allergies, diabetic desserts and pure food (puree). Meals are delivered in thermal boxes served from a bain-marie in the kitchenette on each floor. The cook and kitchenhand serve meals in the studio apartments and the caregivers serve on the care centre floor.</p> <p>There has been a recent survey and meetings with the residents for feedback of the menu and suggestions, the menu was created and approved by the dietitian to accommodate requests. A new initiative of delivering a weekly menu for residents to choose the meals they would like has been implemented, with alternatives available, as some residents prefer a lighter meal option in the evening. Fridges and freezer temperatures are monitored daily. End cook food temperatures are recorded daily. All temperatures are within policy guidelines. Chemicals are stored appropriately. Food safety training occurs annually. Residents interviewed were very complimentary of meals. Breakfast club – buffet style continental breakfast is available in the dining rooms for residents to choose their breakfast or breakfast can be delivered to their room.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The service provides care for residents requiring rest home and hospital level care. Five files were reviewed for the audit, all have interventions relevant to resident needs. Staff have access to adequate medical and continence supplies. Monitoring forms include (but are not limited to): vital signs; fluid balance; weight; blood sugar monitoring; falls risk; pressure risk; pain risk; and behaviour monitoring.</p> <p>Progress notes reviewed evidenced a follow-up assessment by a RN when a caregiver documented a concern or observation or there was a change in the resident's condition. There were six wounds in total being managed by the service (one pressure injury stage 2, 2x bilateral chronic leg ulcers and 2 skin tears. Wound charts were reviewed, all had assessments plans and evaluations which show progression or deterioration of the wound. The wound care specialist has been involved with chronic ulcers and a referral has been sent to the plastic surgeon for input to another chronic wound.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	<p>FA</p>	<p>The service employs a diversional therapist and two activities assistants. The service has recently started to implement the household model for activities and are introducing household meetings with the activities team (minuted) on a weekly basis to empower the residents to have more choices and control their budget for activities. There are three households of fourteen residents. Activities can be provided for each household or combined with</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>all three households. Activities have included a cultural theme including a Hawaii night, and dressing in their pyjamas to have a movie night with popcorn. A walking group has been developed. Staff were enthusiastic when talking about the household models and feel their care and involvement in activities has made the care they provide more holistic and not so task orientated.</p> <p>Relatives and volunteers are part of the household model. The management team joined the Christmas ride; they went on a van outing around the city to see the Christmas lights, while enjoying wine and chips on the trip. The Arvida 'communal' activities calendar is still in place with the provided activities such as exercises, happy hour and entertainers. Various church denominations visit the facility on a rotational basis. The residents visit local schools and teach the children how to knit and make pom-poms. The residents are now filling in the blank spaces to fit their needs. The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme. The initiatives from the previous continuous improvement such as kitchen corner, cycling without age, and Rickshaw rides continue with volunteer input.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>In all five files reviewed, all initial care plans have been evaluated to develop the long-term care plans in conjunction with the outcomes of the interRAI assessments. In four out of five files, the interRAI assessment and the long-term care plans have been reviewed six-monthly to evaluate progress towards the achievement of the desired goal. In the file of the resident who had been in the facility less than six months, all initial assessments and care plan had been reviewed. Long-term care plans are updated when there is a change in health status. Assessments have been reviewed six-monthly and more frequently in the event of a fall or change in health status.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current warrant of fitness which expires 1 March 2019. Equipment has been checked and calibrated. Essential contractors are available 24-hours. There is a preventative maintenance schedule. A maintenance book is maintained and checked regularly throughout the day. Hot water temperatures are checked randomly in resident rooms, satellite kitchen and main kitchen monthly. All temperatures are within range. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and courtyards on the ground floor. Seating and shade is provided. Staff interviewed feel they have enough equipment to meet resident need.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with</p>	<p>FA</p>	<p>The infection control coordinator (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. A delegate from each department within the facility is part of the Infection Control Committee. Individual infection report forms are logged onto the electronic resident file system, and are completed for all infections, which creates the infection register. Infections are collated in a monthly report which is analysed for trends and is included in the facility</p>

<p>agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>monthly report to Arvida. The infection control programme is linked with the quality management programme. The programme is reviewed annually and on a month by month basis, for comparisons.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs and the infection control specialist at the DHB that advise and provide feedback/information to the service. There has been one respiratory outbreak which involved a number of residents in July 2018. All notifications were made in a timely manner. The staff were updated and a debrief was held post outbreak. Relatives and residents were updated during the outbreak.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. On the day of the audit there were no residents with any restraints and one resident using an enabler (lap belt). The file for the resident with an enabler showed that enabler use was voluntary. Assessment, consent form and the use or risks associated with the enabler were evidenced in the resident file reviewed. Staff received training on restraint minimisation in June 2018.</p>

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, there 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.