

# Lexall Limited

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## 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:** Lexall Limited

**Premises audited:** Lexall Care

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

**Dates of audit:** Start date: 29 April 2015 End date: 30 April 2015

**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:** 54

# Executive summary of the audit

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## 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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Lexall Care provides rest home and hospital care for up to 58 residents. On the day of audit there were 54 residents.

This certification audit was conducted against 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, interviews with residents, family, management, staff and a general practitioner.

The facility is governed by a general manager and manager who are supported by an appropriately qualified and experienced clinical manager (registered nurse). Residents and families interviewed spoke positively about the care and services provided.

Improvements are required around complaints management, residents meetings and surveys, completing the education plan, wound assessment, fridge temperature monitoring, and restraint documentation and monitoring.

## 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 Lexall Care 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 services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent and advanced directives are documented. A complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

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

Lexall Care has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data to identify trends and areas for improvement. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific

information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

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## 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 low risk.
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There is a comprehensive admission procedure. A registered nurse assesses and reviews resident's needs, outcomes and goals with the resident and/or family. Care plans are developed and demonstrate service integration. Changes to health status and interventions required are updated on the care plans to reflect the residents current health status. Resident files include notes by the GP and allied health professionals. Medication policies reflect legislative medicine requirements and guidelines. All staff responsible for administration of medication complete education and competencies. An activities programme is in place. The programme includes outings, entertainment and activities that meet the recreational preferences and abilities of the residents. All

food is prepared on site. All residents' nutritional needs are identified and documented. Choices are available. Meals are well presented and a dietitian has reviewed the menu plans.

## 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.

Chemical are stored safely. The building holds a current warrant of fitness. Rooms are spacious and personalised. Communal areas are easily accessed with appropriate seating and furniture to accommodate the needs of residents. External areas are safe and well maintained. There adequate communal showers for the residents that don't have ensuites. Fixtures, fittings and flooring are appropriate. Cleaning and laundry services are monitored through internal audits. Appropriate training, information and equipment for responding to emergencies have been provided. There is an approved evacuation scheme and emergency supplies for at least three days. Registered nurses hold a current first aid certificate. The temperature of the facility is comfortable. Electrical equipment is checked annually. Hot water temperatures are monitored.

## 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.

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

There is a restraint policy that includes comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were nine residents requiring restraints and two residents using enablers. The service reviews restraint as part of the quality management and staff are trained in restraint minimisation. Not all restraint documentation is completed as per policy.

## 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. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

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## 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	43	0	6	1	0	0
Criteria	0	94	0	6	1	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

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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	Discussions with staff confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Eight residents (four rest home and four hospital) and four relatives (one rest home and three hospital) were interviewed and 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	Informed consent and advanced directives were recorded as evidenced in the eight resident files reviewed (three rest home and five hospital). Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed.

<p><b>Standard 1.1.11: Advocacy And Support</b></p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.</p>
<p><b>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</b></p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the facility.</p>
<p><b>Standard 1.1.13: Complaints Management</b></p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>A complaints policy and procedures have been implemented and residents and their family/whanau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register has been maintained, however, not all complaints on the register have an accompanying complaints form or evidence of communication, investigation or documentation of resolution as per policy. There are seven documented concerns or complaints received in 2015. There was no evidence of documented response to or follow up in regard to these. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p><b>Standard 1.1.2: Consumer Rights During Service Delivery</b></p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that include the Code, complaints and advocacy. 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 of rights. Resident meetings and a resident and family survey have not been undertaken in the last two years to provide the opportunity to raise concerns (link# 1.2.3.6). Advocacy and code of rights information is included in the information pack and are available at reception.</p>

<p><b>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</b></p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment.</p> <p>Interdenominational church services are held every second Thursday as well as a Catholic service on a Sunday and a Korean Catholic service on the first Thursday of the month. Resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.</p>
<p><b>Standard 1.1.4: Recognition Of Māori Values And Beliefs</b></p> <p>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.</p>	FA	<p>The service has a Maori heath plan and an individual's values and beliefs policy which includes cultural safety and awareness.</p> <p>Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There was one resident at Lexall Care who identifies as Maori at the time of the audit. The service has established links with local Maori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety.</p>
<p><b>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</b></p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. The facility had ten Korean and one Chinese resident at the time of audit, interpreters are available and the residents specific cultural needs are identified.</p> <p>Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>
<p><b>Standard 1.1.7: Discrimination</b></p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process includes the signing of house rules and a service code of conduct. 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</p>

		dignity and privacy and boundaries. Registered nursing staff have completed training around professional boundaries.
Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard.	FA	The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The Clinical Manager is responsible for coordinating the internal audit programme. A variety of staff meetings are conducted.  Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the nurse manager. Care staff complete competencies relevant to their practice.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings had not occurred for two years (link#1.2.3.6). The managers have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English the interpreter services are made available.
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Lexall Care is privately owned and managed by the owners (general manager and manager) who are supported by a full time clinical manager (RN). The service provides care for up to 58 residents at hospital and rest home level care. On the day of the audit, there were 54 residents in total (21 residents at rest home level, including one respite and 33 residents at hospital level including one receiving interim care).  The experienced clinical manager has been in the role for two years since the hospital opened and was previously the nurse manager of the

		facility for 14 years. The current strategic plan and quality and risk management plans are being implemented. The service has a long term goal to gain resource consent to extend additional 55 beds. Advised, that this is a 2-3 year plan.
Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The clinical manager covers any absence of the manager and general manager. A charge nurse covers any clinical manager absence.
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 Low	The quality manual and the business, quality, risk and management planning procedure describe the Lexall Care's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is being monitored through the quality improvement meeting, and the various facility meetings. Monthly and annual reviews have been completed for all areas of service. Meeting minutes have been maintained and staff were expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirmed their involvement in the quality programme. Resident/relative meetings have not been held for two years. Resident satisfaction surveys to gather feedback on the service provided have not been undertaken for two years. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2014 has been completed. Areas of non-compliance identified at audits have been actioned for improvement. Specific quality improvements have been identified. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies are implemented for individual residents.

<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident forms for April 2015 were reviewed. All forms and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data with other facilities.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates are kept. Nine staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed since the facility opened 15 years ago. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Care workers are orientated by 'preceptors'. Annual appraisals are conducted for all staff. The in-service calendar for 2013-14 was not fully completed. Care workers have completed either the national certificate in care of the elderly or have completed or commenced an aged care education programme. The clinical manager and registered nurses attend external training including conferences, seminars and education sessions with the local DHB.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Lexall Care has a four weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is at least one registered nurse on duty at all times. The full time clinical manager is also a registered nurse. Caregivers and residents and family interviewed advised that sufficient staff are rostered on for each</p>

		shift. All registered nurses have been trained in first aid and CPR.
Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Information containing sensitive resident information are not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts have been stored in a separate folder. Archived records are stored securely on site.
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 identified.	FA	The service has information for potential residents and information which they give to residents on admission. This information includes all relevant aspects of the service and residents and family/whanau are provided with associated information such as the Health and Disability Code of Rights and how to access advocacy. All potential admissions are checked to ensure they have a completed needs assessment and the service can provide the level of care. The two charge nurses interviewed stated that there is good liaison and communication with needs assessors, social workers, mental health team and general practitioners and nurse practitioners. There is an admission policy and procedure. The service has recently reviewed and updated their admission agreement and this aligns with a) - k) of the ARC contract. The eight admission agreements sighted had all been signed within the required time frame.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a policy and procedure for death, discharge and transfer. When transferring all relevant documentation is written on a transfer form accompanied with medication sheets and recent GP notes. Resident transfer information is communicated to the receiving health provider or service. There is documented family notification of appointments and transfers. Relatives interviewed stated they were

		kept informed of the resident's condition.
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 Low	<p>Medications are managed appropriately in line with accepted guidelines. Registered nurses administer medications, at times senior medication competent caregivers administer medications under RN direction. All staff administering medications have completed an annual medication competency.</p> <p>The service uses a robotic roll system for medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. There is a small stock of hospital stock kept in a locked cupboard in the medication room. Medication fridges do not have their temperature monitored. All controlled drugs are checked weekly. Self-medication residents are managed in line with accepted guidelines.</p> <p>The sixteen medication charts sampled included photo ID and allergies. The charts were clear and charted correctly. The signing sheets corresponded to the medication chart. All medication charts sampled showed evidence of being reviewed by the GP three monthly. Standing orders complied with accepted guidelines.</p>
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	<p>All food is cooked on site in the main kitchen. The food is transported to dining rooms in bain maries. The temperature of the food is checked before leaving the kitchen. There are two cooks who rotate shifts. They are supported by a kitchen hand. Both cooks have a current food safety and hygiene certificate. The kitchen hand has completed food safety and hygiene in-service. There is a kitchen manual and cleaning schedule. There are seasonal menus on a four weekly cycle and these have been approved by a consultant dietitian. The cooks receive dietary information for new residents and are notified of any dietary changes, weight loss or other dietary requirements. Special diets and allergies are on laminated notices on the fridge door. Normal and moulied meals are provided. On a Friday, the Korean residents receive a Korean meal. Fridge and freezer temperatures are recorded daily. Temperatures are recorded on all chilled and frozen deliveries. All food</p>

		<p>in the chiller, fridges and freezers are dated. There is sufficient food stored to last for at least three days in an emergency. Stock is rotated by date. The kitchen is well equipped, clean and tidy. Residents and relatives interviewed said the food was mainly satisfactory. No evidence of resident satisfaction surveys since 2013 (<a href="#">link1.2.3.6</a>).</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></p> <p>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.</p>	FA	<p>The service records the reason (no bed available or unable to meet the acuity/level of care) for declining admission to the service. Potential residents are referred back to the referring agency if declined.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files reviewed identified that falls risk, pressure area risk, nutritional, continence, patient handling and activities assessments were completed on admission. Pain and challenging behaviours assessments were completed as required. The outcomes of risk assessments were reflected in the eight care plans sampled and interventions identify required support. However restraint assessments were not undertaken prior to commencement (<a href="#">link 2.2.2.1</a>)</p>
<p><b>Standard 1.3.5: Planning</b></p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed were comprehensive and demonstrated service integration with input from allied staff. The exception to this was restraint where care plans did not detail what restraint/enabler is used and the associated risks or minimisation strategies (<a href="#">link 2.2.3.4</a>). Residents interviewed confirm care delivery and support by staff is consistent. There is documented evidence on the care plan and in the family contact notes of family involvement in the care plan process. Acute care plans are in use for short term needs and changes in health.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>The long term care plan is readily available for caregivers. When a resident's health status changes the registered nurse will review the resident and if required will ask the GP or other health professionals for a consultation. There is documented evidence on the family contact sheet of family notification when a resident's health status changes. All</p>

		<p>relatives interviewed stated that staff were approachable if they needed to discuss their relative's health at any time.</p> <p>Dressing supplies are available and dressing trolleys were well stocked in each treatment room. Continence products are available and it is recorded in the care plans reviewed which product is needed and when.</p> <p>Wound assessments reviewed were incomplete. However, there were explicit guidelines for staff including diagrams in wound care plans. There is GP involvement in wound care as necessary and for one pressure area on an ankle there is wound care specialist involvement.</p> <p>Acute care plans are in place. Monitoring forms are in use as directed by the registered nurses. Restraint monitoring is incomplete (link 2.2.2)</p>
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	<p>There is one qualified diversional therapist who works 33 hours from Monday to Saturday. The monthly activity programme is displayed on noticeboards. The theme of the month at the time of audit was Kiwiana. There is a range of activities to meet most needs including entertainment, bingo, bowls, craft and games. Community groups such as choirs visit frequently. Group exercises are held daily and the physiotherapist has input into these. There is a van outing every Friday. The van is hired. Church services are held every second Thursday. There is a Catholic service on a Sunday and a Korean Catholic service on the first Thursday of the month. The diversional therapist states that the programme changes according to the mix of residents. Variations to the programme are notified to the residents.</p> <p>The diversional therapist has one on one time with residents who are unable or who choose not to participate in the programme. On the days of audit activities were seen to be taking place and most residents were actively engaged.</p> <p>Special occasions and birthdays are celebrated, for example Anzac Day. All residents are encouraged to participate.</p> <p>The diversional therapist completes an individual activity plan on admission which includes previous hobbies, community links, family and interests. Residents feedback on activities to the diversional therapist and changes are made as required.</p>

<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plan evaluations reviewed were documented by the registered nurses six monthly or as necessary. There were acute care plans available to focus on acute and short term issues. These were evaluated regularly. The GP completes three monthly reviews including medications. Family are invited to attend and have input into the reviews.</p>
<p><b>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</b></p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services was evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation was maintained on resident files. Examples of referrals sighted were to dietitian, wound care specialist and mental health services.</p> <p>Discussions with registered nurses identified that the service has access to GP's, ambulance/emergency services, allied health, dietitian, wound specialists and social workers.</p>
<p><b>Standard 1.4.1: Management Of Waste And Hazardous Substances</b></p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There is a waste and hazardous substance safety policy. Management of waste and hazardous substances is covered during orientation. Chemical safety training has not been completed in the last year (link 1.2.7.5). All chemicals are stored in locked cupboards. Safety data sheets and product wall charts are available. Approved sharps containers are used. These are easily identifiable. Gloves, aprons and face shields are available for staff use and staff were observed wearing appropriate protective equipment when carrying out their duties.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness. Reactive and preventative maintenance occurs. There are two maintenance people on staff who are also responsible for the garden. Outside contractors check and calibrate medical equipment annually and hoist six monthly. Hot water temperatures are monitored and recorded. They are maintained between 43-45 degrees Celsius. There are contractors for essential services available and on call. Electrical testing and tagging</p>

		<p>has been completed April, 2015.</p> <p>The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets. The corridors are very wide in the new area and adequate in the old area. There are handrails in all corridors which promotes safe mobility. Residents were observed moving freely around the areas with mobility aids if required. The external areas and gardens are well maintained and easily accessible (including wheelchairs). There is outdoor furniture and seating and shaded areas. There is a large picture window in one of the lounges and residents were observed enjoying the view. The registered nurses interviewed stated that they have all the equipment referred to in care plans necessary to provide care.</p>
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	All resident rooms in the new area have ensuites. In the old area there are toilets and hand basins in each room and adequate numbers of communal shower rooms. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Shower rooms are private. The residents interviewed reported that privacy is maintained at all times.
Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is one double room which has a dividing wall down the middle. The rest of the rooms are single. All rooms are spacious and it is easy for staff to manoeuvre transferring and mobility equipment to safely deliver care. Residents are encouraged to personalise their rooms.
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 are spacious lounges in each area and there are also smaller areas where residents can sit alone or in small groups. Each area has a dining room. There is a café with tea/coffee making facilities for staff and residents. All lounge/dining areas are accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture is arranged to facilitate this. The lounges/dining rooms can accommodate lounge chairs. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There is a cleaning policy and cleaning schedules in place. There is a laundry policy and schedule. Only personal washing is done on site. All chemicals are labelled. Personal protective equipment is available and easily accessible for cleaners and laundry staff. Cleaning trolleys are locked in cupboards when not in use or have all chemicals removed from them. Safety data sheets are in the sluice rooms, chemical storage cupboard, cleaner's cupboard and laundry. Cleaning and laundry staff were observed wearing appropriate protective wear when carrying out their duties. Cleaning of carpets is carried out as required. There were adequate linen supplies sighted. Linen is washed off site.</p>
<p><b>Standard 1.4.7: Essential, Emergency, And Security Systems</b></p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Appropriate training information and equipment for responding to emergencies is provided. All registered nurses have a current first aid certificate. There is an approved fire evacuation scheme. Fire evacuations are held six monthly. There is a civil defence and emergency policy and procedure in place. The facility has an emergency civil defence kit – kept in the upstairs treatment room and maintained by the registered nurses. There is a spills kit. The facility has emergency lighting. There are gas barbeques that can be used for cooking. Emergency food supplies sufficient for three days are kept in the kitchen. There are extra blankets available. There are sufficient stocks of continence products and personal protective equipment. In the event of a power failure residents on oxygen concentrators can be switched to oxygen cylinders and there are back up batteries and torches. The call bell system operates in all areas. Staff ensure the building is secure overnight. Reception monitors visitor entry by day.</p>
<p><b>Standard 1.4.8: Natural Light, Ventilation, And Heating</b></p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All communal rooms and resident rooms are well ventilated and light. The temperature of the facility is comfortable and can be increased or decreased as necessary. All resident rooms have external windows that let in natural light.</p>
<b>Standard 3.1: Infection control management</b>	FA	Lexall Care has an established infection control (IC) programme. The

<p>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.</p>		<p>infection control programme has been appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. A registered nurse has been appointed as the designated infection control officer with support from the clinical manager (infection control co-ordinator). The IC matters are reviewed at facility quality meetings. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</p>
<p><b>Standard 3.2: Implementing the infection control programme</b></p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Lexall Care. The infection control co-ordinator has maintained her practice by attending infection control updates. The infection control team is representative of the facility. External resources and support are available when required. 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.</p>
<p><b>Standard 3.3: Policies and procedures</b></p> <p>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.</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly.</p>
<p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control nurse with support from the infection control officer. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and were advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014.</p>

<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. The clinical manager is the infection control co-ordinator and is supported by a registered nurse who is the infection control officer. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly facility infection summary and staff were informed. The data has been monitored and evaluated monthly and annually. An outbreak of norovirus in February 2014 affecting 17 residents was appropriately managed, with notification to the relevant authority.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service is committed to restraint minimisation and safe practice. Restraint minimisation is overseen by a restraint coordinator who is the clinical manager. There were nine residents requiring bedrails as restraint and one of these also utilises a lap belt when in a wheelchair. Two hospital residents were using bedrails as enablers. The use of enablers is voluntary, requested by the resident. A full restraint assessment is required to be completed prior to implementing the enablers (link 2.2.2.1). There is evidence of the residents consenting to the enabler. In addition, there is evidence of monitoring of residents who were using enablers.</p>
<p><b>Standard 2.2.1: Restraint approval and processes</b></p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint coordinator is the clinical manager (registered nurse). Assessment and approval process for a restraint intervention included the restraint coordinator, registered nurse, resident/or representative and medical practitioner</p>
<p><b>Standard 2.2.2: Assessment</b></p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	PA Low	<p>The service has a policy that directs staff to complete comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, restraint</p>

		<p>officer, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the four files reviewed (two restraint and two enabler), assessments were not fully completed. Consent for the use of restraint was completed with family/whanau involvement and a specific consent for enabler / restraint form was used to document approval.</p>
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Moderate	The restraint minimisation manual identified that restraint is only put in place where it was clinically indicated and justified and approval processes. There is an assessment form/process that is to be completed for all restraints and enablers. The four care plans reviewed did not detail that a restraint or enabler was in use or the associated risks/minimisation strategies. Monitoring forms were in use but these did not evidence the two hourly monitoring reported by staff, the monitoring forms had times the restraint/enabler was put on and off only. The files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. The service has a restraint and enablers register which is updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator at quality and staff meetings meeting. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly meetings. There are six monthly restraint meetings held.



## Specific results for criterion where corrective actions are required

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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 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	A complaints register is in place and completed for all concerns and complaints.	There was no documentation on file to support acknowledgement, investigation or follow up of complaints.	Ensure all complaints registered in the complaint log include documentation to support follow up action.  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	The quality manual and the business, quality, risk and management planning procedure describe the Lexall Care's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the quality	There was no evidence of resident meetings or satisfaction surveys being undertaken in the last two years.	Ensure satisfaction surveys and resident meetings are undertaken to gather feedback on the service provided.

		improvement meeting, and the various facility meetings		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	An education plan is in place to ensure staff receive compulsory education sessions as well as other relevant training to enable them to care for the residents in the service.	The education plan for 2013-2014 was not fully completed. Cultural, continence, sexuality and intimacy and chemical safety training have not been provided in the last two years.	Ensure the education plan is completed as per schedule and all compulsory training is undertaken by staff.  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 Low	All medications are prescribed correctly. Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The two medication rooms were checked. No medication fridges are having temperatures recorded.  Staff sign for the administration of medications on medication sheets held with the prescribing sheet. Signing sheets correspond to instructions on the medication chart and all charts sampled evidenced that medication had been signed for. There is a list of specimen signatures in each medication area.	Temperatures of medication fridges were not being monitored or documented.	Ensure temperatures of the medication fridges are monitored and recorded  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 Low	Wound assessments and wound care plans were developed for all wounds. Interventions and evaluations were well documented. There were explicit guidelines for staff including diagrams.	Wound assessments reviewed were incomplete with no description of the wound, no skin tear category stated and in some incidences no wound site stated.	Ensure wound assessment documentation is fully completed for all wounds.

				60 days
<p><b>Criterion 2.2.2.1</b></p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <ul style="list-style-type: none"> <li>(a) Any risks related to the use of restraint;</li> <li>(b) Any underlying causes for the relevant behaviour or condition if known;</li> <li>(c) Existing advance directives the consumer may have made;</li> <li>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</li> <li>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</li> <li>(f) Maintaining culturally safe practice;</li> <li>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</li> <li>(h) Possible alternative intervention/strategies.</li> </ul>	PA Low	<p>The service has a policy that directs staff to complete comprehensive assessments for residents who require restraint or enabler interventions.</p>	<p>The four files reviewed (two restraint and two enablers), assessments were not fully completed.</p>	<p>Ensure assessments are completed</p> <p>90 days</p>
<p><b>Criterion 2.2.3.4</b></p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include</p>	PA Moderate	<p>A restraint register is completed for all restraint use and is current.</p> <p>Documentation is available to ensure all restraints and enablers are minimised, consented, detailed on the care plan, monitored and evaluated.</p>	<p>The four care plans reviewed did not detail that a restraint or enabler was in use or the associated risks/minimisation strategies. Monitoring was not documented as undertaken two</p>	<p>Ensure all restraint documentation is completed within set timeframes.</p>

<p>but is not limited to:</p> <ul style="list-style-type: none"> <li>(a) Details of the reasons for initiating the restraint, including the desired outcome;</li> <li>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</li> <li>(c) Details of any advocacy/support offered, provided or facilitated;</li> <li>(d) The outcome of the restraint;</li> <li>(e) Any injury to any person as a result of the use of restraint;</li> <li>(f) Observations and monitoring of the consumer during the restraint;</li> <li>(g) Comments resulting from the evaluation of the restraint.</li> </ul>			<p>hourly as per policy.</p>	<p>60 days</p>
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## **Specific results for criterion where a continuous improvement has been recorded**

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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.