

# Kaylex Care (Waipukarau) Limited - Mt Herbert House

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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 The DAA Group 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:** Kaylex Care (Waipukarau) Limited

**Premises audited:** Mt Herbert House

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

**Dates of audit:** Start date: 10 February 2016      End date: 11 February 2016

**Proposed changes to current services (if any):** This certification audit includes a part provisional audit to add hospital services – medical - to the scope of services included on the certificate. Since the last on site audit there has been a reconfiguration within the facility with one small lounge and a bathroom being converted into four additional bedrooms; three in the hospital area of the facility and one in the rest home area of the facility.

The provider is seeking to change the designation of their beds from a total of 38 beds to a total of 42 beds, made up of 22 hospital beds (the existing 18 hospital beds and four new beds), and 20 dual use beds (the 20 current rest home care beds).

**Total beds occupied across all premises included in the audit on the first day of the audit: 39**

# 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   |
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|   | 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

Mount Herbert House is situated in Waipukurau, Central Hawke's Bay. It is one of three facilities in the Kaylex Care group of aged care facilities, owned privately and with executive oversight from the Hibiscus Coast. Mt. Herbert House provides rest home and hospital care services. This routine certification audit has encompassed several changes and additions to the facility, including: the addition of four new bedrooms, bringing the total number of bedrooms to 42. Kaylex Care is seeking to change the designation of the beds to 20 dual use beds and 22 hospital level beds. They are also wishing to add hospital services (medical) to the scope of their certification. They are in discussions with the Hawke's Bay District Health Board to extend their services to include palliative care and intermediate care.

This audit against the Health and Disability Services Standards included review of a sample of residents' files, interviews with residents, relatives and staff, and observation of the environment. Sampling included a focus on the care of two residents through their stay at Mt Herbert House. Information gathered was used to determine the effectiveness of care, service delivery and the organisation's systems.

There is a strong focus on the needs of residents with effective care planning and goal setting. The facility has been using interRAI assessments to inform care planning for four years and all nursing staff are interRAI trained. No areas for improvement were identified in this audit.

## Consumer rights

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| 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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There are well-established systems and processes to ensure residents' rights are respected and maintained. Staff receive regular and ongoing training on rights and demonstrated a clear understanding of how these should be implemented on a daily basis to ensure resident independence is promoted, personal privacy respected, individual needs met and dignity is maintained. During the audit visit, residents were observed to be treated in a professional but warm and unhurried manner.

Policies are in place to ensure residents are free from discrimination or abuse/neglect, with these policies well understood by staff.

Residents and their families reported their satisfaction with the services provided, and of the open communication with staff.

There is a complaints process that is understood by residents, family members and staff and meets the requirements of the Code of Health and Disability Services Consumers' Rights. A complaint made to the Health and Disability Commissioner was finalised in early 2015. The facility manager and director complied with all requirements of the decision from the Commissioner.

## Organisational management

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| 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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Kaylex Care (Waipukurau) Ltd has an owner/director based in the Hibiscus Coast and a facility manager and clinical nurse manager in the facility who are both registered nurses. The clinical nurse manager is currently acting in the position and covering the role of a colleague on parental leave. However, she has held the role herself for a number of years. She is referred to in this

report as the acting clinical manager. Another registered nurse in the facility is being mentored to support the clinical manager. Reference to this person is made in this report as clinical manager in training.

The organisation has a documented vision and mission statement which is included in their strategic documents and is reviewed annually. These are available to staff and are on display in the facility. The facility manager has a position description which gives her the authority to undertake the responsibilities of her role and she has the necessary skills and experience for the role. In a temporary absence of the facility manager, the director will support the (acting) clinical manager, covering her absence.

There is a quality and risk management system in place which provides reporting to Kaylex Care head office, and incorporates analysis and evaluation of quality improvement data to identify and manage trends. The quality and risk management plan outlines objectives which are implemented, along with an internal audit programme and management of risks. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective action planning, feed into the quality improvement cycle to manage any further risk and ensure continuous quality improvement occurs.

There are appropriate systems for the recruitment, appointment and management of all employees. This includes orientation and an ongoing education plan for all staff. All nursing staff have current professional development and recognition portfolios and all other staff hold a current national certificate relevant to their position. The facility has adequate numbers of nursing, care giving, house-keeping and diversional therapy staff to provide support and care to the residents living at Mt Herbert House.

All aspects of information management comply with best practice and legislative requirements.

## Continuum of service delivery

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| 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. |
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Registered nurses are on duty 24 each day, with either the nurse manager or the two acting clinical nurse managers on call after hours. Resident progress notes are updated each shift for hospital-level residents, and at least daily for rest home-level residents.

There are also well-developed processes in place, such as verbal handovers and communication sheets, to guide continuity of care.

The national assessment system, interRAI, is used very effectively at Mt Herbert House as the basis for identifying resident's individual needs, and developing care plans that reflect a comprehensive range of clinical information, and include input from residents and families. Registered nurses are responsible for residents' assessments, care planning and evaluation, all of which are carried out in a timely manner.

Two experienced and enthusiastic recreation coordinators are responsible for a diverse activity programme, which offers residents a variety of individual and group activities. Residents are encouraged to maintain their links with the community and participate in a range of community events.

The kitchen was well organised and maintained in a clean and hygienic manner. Staff have the appropriate food safety qualifications and all aspects of food services were well managed. The individual food preferences and dietary needs of residents are respected and catered for. There are two separate dining areas for residents.

All aspects of medication administration are safe and consistent with best practice guidelines and legislative requirements. Registered nurses, who have been assessed as medication competent, administer all medications. Medications are prescribed appropriately, and medication administered records are complete.

All components of the service delivery system could accommodate an additional four residents.

## Safe and appropriate environment

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| 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. |
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The facility is purpose built and well maintained. Residents' rooms are kept clean, tidy, well ventilated and at a comfortable temperature. There are a number of communal areas which provide a variety of spaces for residents to use, including an activities lounge and a library, games room. There are a sufficient number of toilets and bathrooms for the number of residents, even with the conversion of one bathroom into a bedroom and the addition of three other new bedrooms.

Easily accessed, safe and attractive outside areas are provided for use for residents. The building has a current building warrant of fitness. There is a current certificate of public use for the rebuilt bedrooms.

Robust systems are implemented for the management of waste and hazardous substances by staff who have been trained in this area.

Emergency procedures are well documented for ease of use and available in a number of places around the facility. Regular fire drills are held and staff are well trained to respond in any emergency. A back-up water tank is on site and relevant supplies for civil defence and other emergencies are located at the facility.

## Restraint minimisation and safe practice

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| 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 management team are committed to providing a restraint free environment and there is no restraint being used at the time of the audit. All alternatives to restraint are considered.

Staff have ongoing training in the management of any challenging behaviours, and the use of restraints and enablers. Policies and procedures meet all the requirements of the standard. Any use of enablers is for safety of residents in response to individual requests.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control coordinator is an experienced registered nurse who has received additional infection control education. Appropriate infection prevention and control systems are in place, with staff offered regular education related to infection control.

Personal protective equipment is freely available to staff, and additional supplies are on site should there be an infection outbreak.

Infection surveillance is systematic, and reported monthly to senior management and staff.

The infection control programme is reviewed annually.

## 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 45                  | 0  | 0                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 1                           | 92                  | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>  | FA                | <p>The orientation of all new staff includes education related to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), as confirmed in staff interviews. Ongoing education on the Code is also available to staff annually, as confirmed in staff education records.</p> <p>During interview, staff demonstrated a clear understanding of the Code and were able to explain how this would be incorporated into their everyday practice.</p>   |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA                | <p>Each resident, and/or their enduring power of attorney (EPOA), completes a comprehensive consent form at the time of admission. This form includes consent for care and general treatment, outings, photographs, and the use of information. Additional consent is obtained on an as-required basis, such as when a resident's needs change, or additional medical/surgical treatment is required. Completed consent forms were seen in all residents' records reviewed.</p> <p>Those residents interviewed stated they were given ample opportunity to make informed choices and that their consent was obtained and respected. Family members confirmed they were informed in a timely manner about what was happening with the resident.</p> <p>Each new resident and/or their family completes an admission agreement, which includes inclusions</p> |

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|  |    | <p>and exclusions in service. Robust systems are in place to ensure that signed admission agreements are held for every resident.</p> <p>There are currently no residents with advance directives, although the acting clinical nurse manager and clinical manager in training advised that any such directives would be respected. The information pack for new residents includes a range of information related to end of life decisions, and there are established and appropriate processes in place to ensure that resident's wishes are respected.</p>  |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>       | FA | <p>As part of the admission process all residents are given a copy of the Nationwide Health and Disability Advocacy Service (Advocacy Service) brochure. Additional copies of this brochure were also available at reception. Residents and family members confirmed on interview their awareness of the Advocacy Service and how to access this. Education on the Advocacy Service was last held in 2015.</p> <p>Information on the Advocacy Service is included in the staff orientation programme and in the ongoing education programme for staff. This was confirmed in staff orientation and training records. On interview, staff demonstrated their understanding of the Advocacy Service, including how to help residents/families contact the service should it be required.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>The service has open visiting hours and visitors are encouraged. All family members spoken with during the audit visit said they felt very welcome when they came to visit.</p> <p>If residents are well enough, they are encouraged to maintain their community interests and to visit their families. The service hires a mobility van so that residents can go on regular outings, and participate in community activities such as attending the local Pakeke Centre, and joining in social activities with other members of the Central Hawke's Bay activities group.</p> <p>Residents are also supported to access health care services outside of the facility, such as visits to the dentist or medical specialists.</p>   |
| <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>There is a complaints process which meets the requirements of the Code, is made available to new residents and their families and to staff at orientation and in the annual training programme. The facility manager maintains the complaints register and manages all complaints, with input from the director when required.</p> <p>A complaint was made to the Health and Disability Commission by a family member on 9th November 2012 in relation to the standard of care given to a resident and after a lengthy investigation a decision</p>   |

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|  |    | <p>was received in January 2015 in which the facility was found to have been in breach of the Code in the care given to the resident.</p> <p>In the intervening time the facility manager, acting clinical manager and director had followed the ensured that the complaint was well managed, the process followed as required, actions implemented to make improvements as requested, including additional training for managers and staff and changes to documentation. The commissioner notified of actions completed and the complaint is now closed.</p> <p>Other complaints are responded to appropriately, recorded on the register and managed within the timeframes of the Code.</p>   |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>  | FA | <p>A copy of the Code and information on the Nationwide Health and Disability Advocacy Service (Advocacy Service) are provided to each new resident and their family/whanau during the admission process, and additional copies are also available at reception. Information on resident rights is also included in the resident admission agreement, and information on the complaints process. The two acting clinical nurse managers (who job-share this position) advised that either they or the facility manager discuss this information with the resident at the time, and answer any questions they might have. Further explanations and discussions are held with individual residents and/or their family as required. Those residents and family members interviewed confirmed their understanding of resident rights and that they had been given information about the Advocacy Service. They also reported that they have or would feel comfortable raising any concerns they might have with the facility manager or senior nursing staff.</p>  |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</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>Every resident at Mt Herbert House has a private room, with many reflecting the encouragement and support residents had been given to personalise the room. During the audit visit, staff were noted to be interacting with residents in a warm, friendly and unhurried manner, addressing them by their preferred name. Resident privacy was maintained when staff were undertaking personal cares, and staff were observed to knock on closed doors before entering. Shared bathrooms all had signs to indicate if they were occupied or vacant, so as to maintain resident privacy. Residents and families interviewed reported they were treated respectfully and their individual needs were met.</p> <p>Privacy of resident information, including clinical files, was maintained. Personal information stored electronically well-organised and password protected; archived resident records were stored securely and easily retrievable and staff handovers were undertaken in a manner that maintained privacy of information.</p> <p>The long-term nursing care plans reviewed included specific information related to maintaining</p> |

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|  |    | <p>residents' independence, and meeting their individual, religious and social needs, values and beliefs. Clinical files included documentation related to resident and/or family involvement in the assessment and care planning process and the ongoing evaluation of progress towards identified goals. This was also confirmed in interviews with residents and families.</p> <p>Staff members interviewed demonstrated good understanding of the service's detailed guidelines related to abuse and neglect, and were able to outline the actions they would take if they suspected this. All staff undergo a police check as part of the employment process and referee checks are completed, as confirmed in human resources records reviewed.</p>   |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</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>At the time of the audit Mt Herbert had one resident and six staff who identified as Maori. One staff member is the identified cultural officer, a role that has been formalised with a job description. The service has a Maori Health policy and the Te Whare Tapa Wha model is integrated into care delivery. There is an extensive cultural safety folder which includes a range of resources to guide staff, together with the names and contact details for a range of Maori health providers and cultural advisers. Three residents' rooms can accommodate larger family groups and a lounge is also available if required.</p> <p>Cultural beliefs and related requirements are incorporated into the resident's admission profile, which then informs the relevant section of the lifestyle care plan.</p> <p>The acting clinical manager and clinical manager in training advised that following the death of a resident, rooms are always blessed by a chaplain prior to the next resident being admitted. An additional Maori blessing of rooms can be arranged.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>           | FA | <p>All care plans reviewed reflected the personal preferences and individual requirements of the resident, with interventions documented to ensure these were met. The acting clinical nurse manager and clinical manager in training described how the service was able to meet the diverse needs of residents. All residents and family members spoken with during the audit visit advised they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected.</p>   |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>   | FA | <p>All residents and family members interviewed stated that residents were free from any type of discrimination or exploitation, and this was also confirmed by the doctor spoken with during the audit visit.</p>  |

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| harassment, sexual, financial, or other exploitation.  |    | The orientation for new staff includes education related to all forms of discrimination and exploitation, and detailed in their individual employment agreements. During interviews, staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.  |
| Standard 1.1.8: Good Practice<br>Consumers receive services of an appropriate standard.  | FA | <p>The service has developed extensive professional networks with a range of health professionals and services, such as district nurses, community mental health team, social worker, physiotherapist and the older person's mental health team. These networks are a source of additional knowledge and expertise to supplement the service's clinical policies, which are current and reflect best practice. The service has also developed a close working relationship with the DHB and the portfolio manager, who are actively involved in supporting staff education opportunities.</p> <p>Senior nursing staff confirmed they are also encouraged and supported to attend external training, such as wound care study days and infection control education. The service has its own syringe pump driver for residents requiring palliative care.</p> <p>On interview, the doctor confirmed confidence in the standard of care provided to residents. The service would be able to accommodate an additional four residents.</p>  |
| Standard 1.1.9: Communication<br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | <p>Each resident's file reviewed contained a written record of communication with family members. These communication records, accident/incident forms and residents' progress notes, demonstrated open disclosure and effective communication with residents/families. When potential or actual communication issues with family members were identified, staff were proactive in working to address these. Families are also sent an individualised written update every six months which summaries the resident's progress, and the outcome of the regular medical assessments. Copies of these were sighted in residents' files. The service produces a newsletter every two months, which is distributed to all residents and posted/emailed to family members.</p> <p>All family members interviewed stated they were informed in a timely manner about any changes to the resident's status. Evidence was sighted of resident/family input into the care planning process.</p> <p>The acting clinical nurse managers advised that interpreter services could be accessed from the DHB as required.</p> |
| Standard 1.2.1: Governance   | FA | There are strategic plans for the facility ( business, quality and risk management plans) which link to Kaylex Care, the governing body. These include the values, mission and vision of the organisation and   |

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| <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>   |           | <p>are reviewed annually by the director.</p> <p>The facility manager is a registered nurse who has been at Mt. Herbert House (MHH) for five years, four as the manager. She has a job description which outlines her role and provides her with the accountability to undertake the responsibilities of her position. At interview with the director who was present for the audit, she confirms that the facility manager is suitably qualified and experienced to undertake her role.</p> <p>The facility manager and director have both been involved in the discussions with the Hawkes Bay District Health Board in planning the extension in the rooms, addition of hospital – medical services to the services the planned changes in service provision to incorporate palliative care and intermediate care. Once the approval is given for the new scope they will commence formal planning for these new services.</p>   |
| <p>Standard 1.2.2: Service Management</p> <p>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.</p> | <p>FA</p> | <p>In the temporary absence of the facility manager, the (acting) clinical manager takes on the day to day management responsibilities of the facilities, with the support of the director. If both the acting clinical manager and the facility manager were unavailable the director takes over the management functions onsite at the facility.</p> <p>The management structure will remain the same with the introduction of the new services.</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>                         | <p>FA</p> | <p>The quality and risk management plan clearly describes the service’s approach to quality and risk management. The facility manager reports on the completion of quality objectives at the end of each year, and these reports were reviewed for 2014 and 2015. Quality and risk is moderated by a quality, health and safety and infection control committee and data is communicated to staff through regular staff meetings and the minutes and relevant graphs are on the staff noticeboard.</p> <p>Where corrective actions are required, these are documented, implemented and monitored for effectiveness through the committee, as confirmed in minutes reviewed. Examples were reviewed with the facility manager during the audit.</p> <p>The director of Kaylex Care maintains the document control and management system. She reviews and updates all policies, procedures and documents when these are due, and circulates them for input and feedback to the facility managers. When the documents changes or new documents developed, the final version is confirmed and sent electronically to the facility manager. It is her responsibility to ensure that all hard copies of documents are current within the facility. All those sighted prior to and</p> |

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|   |           | <p>during the onsite audit were current and had been reviewed in the time frame determined by the organisation.</p> <p>The quality, health and safety and infection control committee reviews all collated event data at their monthly meetings. The standard agenda incorporates the identification of trends and corrective action management, management of individual events or issues, and planning and implementation of quality improvement projects. Meeting minutes were reviewed and demonstrated a consistent and regular history of meetings and quality management activity within the facility.</p> <p>Risks are managed through the strategic planning documents (the MHH business plan, quality and risk management plan), the formal monthly reporting by the facility manager to Kaylex Care head office, and the informal contact between the facility and the director and general manager - finance. The finance general manager also attended the audit with the director to support MHH team. At interview all three managers spoke about the risk management processes of the organisation as a whole and MHH in particular. A review of randomly sampled monthly reports from the facility manager and minutes of the fortnightly Kaylex Care group managers confirms the systems reported.</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> | <p>FA</p> | <p>There are policies and procedures which guide all staff in the reporting and recording of all types of adverse events which occur within the facility. This incorporates open disclosure and essential notifications and statutory and regulatory reporting as required by these standards and the organisation's contracts. At interview with the director and facility manager they described these procedures and demonstrated an understanding of their responsibilities.</p> <p>A review of the adverse event forms and collated event data also demonstrated that there is a system in place which is capturing the range of event types which occur at MHH. There is appropriate categorisation of events and when necessary there is escalation of reported events to the director at Kaylex Care head office.</p> <p>Since the completion of the reconfiguration and completion of the four new bedrooms, there has been no negative impact on the level of adverse events.</p> <p>A pressure injury being managed at the time of the audit had not previously been reported under section 31 of the Health and Disability Services (Safety) Act because the facility was attempting to gain specialist advice to assess the injury and had been unable to do so. At interview the facility manager and director understood their responsibilities for reporting level 3 assessed pressure injuries. On discussion with the clinical auditor a decision was made to send a notification. (See standard 1.3.3 for more detailed information).</p> |

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| <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 legislation.</p> | <p>FA</p> | <p>There are appropriate policies and procedures to guide the recruitment, appointment and management of employees at MHH. These include the validation of professional qualifications. In the last 18 months the facility has been involved in the Hawke's Bay District Health Board's (HBDHB's) Nursing Entry to Practice (NETP) programme. They have been able to recruit new nursing staff from this programme when there have been vacant positions. Once employed, the facility manager and the administration office monitor and maintain a register of all practising certificates. This was reviewed during the audit and all nursing staff members have a current practising certificate with no restrictions to their scope of practice.</p> <p>A review of a random sample of personnel files was completed. This demonstrated that staff members have been through an appropriate recruitment and appointment process, have had an orientation and are involved in ongoing training and development. A range of staff members were interviewed during the audit and they confirmed this. They believe that they have access to a wide range of training and development which gives them the skills and knowledge they need to provide safe care to residents. The housekeeping and caregiving staff members reported that they value the opportunity to gain qualifications as well.</p> <p>Other than two staff members who commenced work at MHH in December 2015, all other staff members at the facility have a qualification relevant to their roles. The full time housekeeping staff member holds three national certificates: the Level 3 certificate in Health and Wellbeing, the certificate in Hauora and the Level 4 national certificate in mental health. This is an objective in their annual quality plan and has been evaluated. An area of continuous improvement is identified.</p> <p>A mandatory training day, delivered on site by a nurse specialist from HBDHB, along with a specific session on wound care in May 2015, has been held. All nursing staff hold syringe driver certification and maintaining this is included in the 2016 training plan and is run by the Cranford Hospice. They also deliver the Hospice NZ palliative care programme for all nursing and care staff. This commenced in 2015 and continues in 2016.</p> |
| <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>       | <p>FA</p> | <p>Staff numbers and skill mix policy provides an appropriate process for the organisation to meet the needs of residents and their contractual requirements, while balancing staffing skill levels due to leave, training and absences for other reasons.</p> <p>The roster in place provides for a safe ratio of nursing and caregiving staff across all shifts, seven days a week to meet the current needs of residents at MHH. There are house-keeping (one full time, seven days a week, and an additional staff member one other day a week), kitchen staff (two full time, seven days a week and a part time staff member for three hours daily covering the evening meal shift) and activities staff (two full time, five days a week). The facility manager and acting clinical manager,</p>  |

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|  |    | <p>both of whom are registered nurses are additional to this.</p> <p>The director and facility manager reported that they have been working closely with HBDHB in developing the new rooms to provide additional hospital level care. There are plans to obtain contracts for the provision of palliative care and intermediate care services. They have not yet received copies of the contracts and service specifications to complete any formal planning, however they know that they will need to review their nursing levels outside of the hours when the facility manager and clinical nurse manager are onsite, all house-keeping and food services, and ensure that the activities programme can accommodate the different needs of the residents who may be referred under these new contracts.</p> <p>Currently only one of the four additional new bedrooms is occupied, although the rooms have been full at different times over the last year since they have been completed. Based on observation, interview with staff and managers and review of adverse events, current staffing levels are managing to provide services to the increased number of residents. Similarly, until the management team has a copy of the new contracts the training currently provided to all staff, and planned for 2016 is appropriate for the needs of the organisation and with addition of the new scope of hospital – medical services.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>All components of the residents' records reviewed included the resident's unique identifier. The clinical records reviewed were well-organised and integrated, including information such as medical notes, reports from other health professionals, laboratory results and assessment findings.</p> <p>Resident-related information is kept in both hard-copy and electronic files. All this information was maintained securely. Electronic files were password protected and can only be accessed by designated staff. Some hard copy information is kept in the nurses' station, where the door was shut if no staff were present. Archived material was well-organised, and stored securely while still being easily retrievable.</p> <p>Detailed resident progress notes were completed every shift for hospital-level residents, while progress notes were updated at least daily for rest-home residents. Registered nurses countersign all progress note entries.</p>  |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p>                    | FA | <p>The acting clinical manager and clinical manager in training outlined the processes associated with admission to the service. Residents must have been assessed by the Needs Assessment and Service Coordination Service (Options) and their support need level confirmed prior to admission. Prospective residents are provided with detailed information about the service, including the admission criteria and associated processes. They and their family/whanau are encouraged to visit the facility prior to</p>   |

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| <p>services has been identified.</p>   |           | <p>admission. Information on the service is available on the internet, and senior nursing staff are also available to provide any additional information required.</p> <p>Family members spoken with during the audit visit said they were satisfied with the admission process and the information that had been made available to them as part of that process.</p>   |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>               | <p>FA</p> | <p>The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. The acting clinical nurse manager and clinical manager in training advised that when a resident is transferred a copy of their care plan, medication chart, advance directive, resuscitation status, most recent progress notes, and a referral form go with the resident. Examples of completed referral forms were sighted in the files of a resident recently transferred to an acute facility.</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> | <p>FA</p> | <p>All aspects of medication management comply with legislative requirements and safe practice guidelines, and would be able to safely accommodate an additional three residents.</p> <p>Medications are supplied using the robotics medication roll system, and these are checked against the medication chart by a registered nurse on arrival to the facility.</p> <p>All medications in the medication trolleys and stock cupboard were within current use date. The date of first use of eye drops was recorded on those products currently in use. A stocktake of all controlled medication is undertaken weekly. Records of the daily check of the medication fridge temperature were sighted.</p> <p>Registered nurses administer all medication in the facility. All these staff have been assessed as competent in medication administration, with records of competency assessments sighted. An observation of a medication round confirmed that medications were administered in a safe and appropriate manner.</p> <p>The service uses the Medi-Map medication system. Each of the twenty medication charts reviewed contained a current photograph of the resident and their allergy status was recorded. All medications were charted in an appropriate manner; the discontinuation of medications was documented, and medication administration records were complete. The service does not use medication standing orders. Processes are in place for residents to self-medicate, should this be required.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>   | <p>FA</p> | <p>All aspects of food service management complied with current legislation and guidelines. Two very experienced cooks are responsible for food services. Both have completed NZQA Unit Standard 167</p>  |

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| <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>   |           | <p>food safety, and also did a refresher course at the EIT in 2015.</p> <p>The kitchen caters for a range of nutritional requirements, including diabetic, soft and puree diets. Specialised crockery, such as lip plate and feeding cups, is available if required. A four weekly menu, with summer and winter options, is currently being reviewed again by a qualified dietitian. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded in the kitchen. Residents are weighed monthly and nutritional supplements administered as prescribed. Two dining rooms are available for residents or they may have meals in their own room if they wish.</p> <p>On inspection, the kitchen was well maintained, clean and tidy. Food was stored appropriately, and food in the chillers, fridge and freezers was dated and covered. Cleaning schedules were sighted and there was evidence of these being implemented. Records were sighted that fridge and freezer temperatures were monitored daily, and remained with the appropriate temperature ranges.</p> <p>Meal services observed during the audit visit were pleasant and relaxed, meals were plated to reflect individual requirements, and there was sufficient staff available to assist residents as needed.</p> <p>Residents spoke of their enjoyment of meals, and appreciated how meals were tailored to meet their individual preferences.</p> <p>Food services have the capacity and expertise to accommodate an additional four residents.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</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> | <p>FA</p> | <p>The acting clinical manager and clinical manager in training advised that if a prospective resident did not meet the entry criteria, or there was currently no vacancy, then they would work with them and Options to support them to find appropriate care/placement.</p>  |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>   | <p>FA</p> | <p>The acting clinical manager and clinical manager in training advised residents are assessed by a registered nurse within 24 hours of admission. A short term care plan is developed utilising a range of information provided by the resident/family, the NASC assessment, clinical assessments such as falls risk and pressure area risk, together with relevant referral information. Within three weeks of admission a full interRAI assessment is completed and a long term care plan developed which reflects the assessment findings. All resident records reviewed included evidence of a comprehensive assessment process, completed in a timely manner, and also involving the resident/family. The</p>  |

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|   |    | assessment of wounds was documented in a detailed manner.  |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>  | FA | All residents have an individualised care plan which provides guidance for care delivery staff to support the resident's identified needs. The service uses the interRAI care plan programme. All resident records reviewed included current and detailed care plan, which reflected the support needs identified by the integrated assessment process. Residents and families stated they felt included in the development of these plans, and their ongoing evaluation.  |
| <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>  | FA | Registered nurses are on duty 24 hours a day who provide support and guidance for care delivery staff. All resident records reviewed included regular, timely and comprehensive ongoing assessment of needs which then informed the provision of care services. Detailed entries were sighted in the resident progress notes especially when there were any changes to resident's needs. The doctor expressed satisfaction with the standard of care provided by the service.  |
| <p>Standard 1.3.7: Planned Activities</p> <p>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.</p> | FA | <p>Two experienced and enthusiastic activities coordinators are responsible for the varied activities programme offered to residents. Both coordinators are currently undertaking formal diversional therapy training. They are members of the Central Hawkes Bay activities group which involves a number of local organisations who meet monthly for joint social activities and outings.</p> <p>Residents' previous and current interests are assessed on admission, individual activity plans are then completed within three weeks and reviewed six monthly. This was confirmed in residents' records. Information from these assessments and evaluations is used to help develop the monthly activities programme, which includes Tai Chi, church services, word games, bingo, quizzes, darts, bowls and crafts. Residents reported how much they enjoyed the activities programme, especially the celebration of festive events, such as the Valentine's Day events observed during the audit visit. Their comments reflected that the diversity of activities available meant there was always something they were interested in.</p> <p>The activities coordinators also facilitate the three-monthly resident meetings, as sighted in minutes reviewed. The activities programme is well-resourced, and has the expertise available to accommodate an additional four residents.</p> |
| Standard 1.3.8: Evaluation  | FA | Registered nurses complete an evaluation of resident progress toward identified goals in conjunction   |

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| <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  |           | <p>with the six-monthly interRAI reassessment, as confirmed in all resident records reviewed. Short term care plans were developed as clinically appropriate, and reviewed in a timely manner.</p>   |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</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> | <p>FA</p> | <p>If the need for other services is identified, the doctor or a registered nurse sends a referral to seek specialist provider assistance. Copies of referrals to a range of health professionals were sighted, such as to the community wound nurse specialist, the diabetes specialists, and mental health services for older persons. Resident/family members confirmed on interview that they are involved in discussions about specialist referrals, and kept informed about progress with the referral processes. Support is available to transport and accompany residents to external health-related visits, as sighted in residents' records and confirmed during interviews with families.</p> <p>The right of residents to access other health and/or disability providers is maintained.</p>   |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</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>                      | <p>FA</p> | <p>Service providers have access to appropriate guidelines for the safe storage and disposal of waste, infectious or hazardous substances. This is made available to them through training, in written policies and procedures and in product safety data sheets from the external supplier of cleaning products. There are supplies of protective equipment and clothing (PPE) available in all locations where they will be required by staff members.</p> <p>When interviewed staff members confirmed that they have access to relevant training, information and PPE to safely perform their roles. They were observed to be wearing and using this throughout the audit. Internal audits conducted in the facility also confirmed use by staff members as required by the organisation's guidelines.</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>There is a current building warrant of fitness for the facility, with a current certificate of public use for the four reconfigured bedrooms. Both were sighted during the onsite audit. The new rooms are all of an appropriate size and dimensions for the provision of hospital level care, albeit that one room is in the rest home wing.</p> <p>The environment is fit for purpose and promotes safety for the resident group. Since the last on site audit the carpeting throughout has been replaced by a non-slip, wood-grain design linoleum. All corridors, communal areas, bedrooms and lounges have been recovered in this same lino flooring. It provides a safe surface for walking, using mobility equipment and when it requires cleaning. (See standard 1.4.6.)</p> <p>Staff members interviewed report that this new flooring is easier to clean and maintain, and that it is</p> |

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|   |    | <p>easier for residents to walk on and use mobility equipment.</p> <p>There is a garden with shaded seating areas on the property and during the audit residents were observed walking outside and using this area. The 2015 family satisfaction survey includes questions about the environment at the facility. The majority of respondents are either satisfied or very satisfied. (One response was 'don't know' and an associated comment from this person was that they live away from the district and rarely visit.)</p>   |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p> | FA | <p>With the additional four bedrooms, there are now ten bathrooms. There were previously 11. The bathroom which has been converted into the fourth bedroom had a large deep bath which was rarely used. With the addition of the four new bedrooms there are still adequate numbers of bathrooms and toilets to meet residents' needs.</p> <p>In addition to the ten bathrooms there are four other separate toilets with hand-washing facilities, one identified for visitors and one for staff members. During the audit visit, there were no issues with access to bathrooms or toilets for residents or visitors.</p>  |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>   | FA | <p>All bedrooms, including the four new rooms, can accommodate the bed, personal furniture and other items, the built in wardrobe and allow for freedom of movement within the room. Residents who use mobility equipment are able to easily manoeuvre in their bedrooms with their equipment.</p> <p>Family satisfaction surveys include questions about bedrooms. All but one respondent in the 2015 surveys were satisfied or very satisfied with their family member's bedroom.</p> <p>The three of the four new bedrooms are all located in the hospital wing, and one in the rest home wing. All rooms in the facility of a similar size and dimension. The rooms are of an appropriate size to accommodate the needs of a hospital level care resident. Doorways can allow for a resident to be moved while in bed.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their</p>  | FA | <p>There are four communal areas for resident use within the facility. The dining room adjacent to the main kitchen, a large activities room, and two other rooms which are used for various activities depending on the day and need. One of these is used as an alternative dining room. Another is a library/games room/reading room.</p> <p>Throughout both days of the audit residents were observed using these rooms both independently for</p>   |

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| relaxation, activity, and dining needs.  |    | individual pursuits and as part of the diversional therapy programme running in the facility.   |
| <p>Standard 1.4.6: Cleaning And Laundry Services</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>The senior housekeeping staff member was interviewed during the audit. She monitors the effectiveness of laundry and cleaning on a daily basis through visual inspection. At interview she confirmed that she is always ensuring that the cleaning and laundry services are being completed to the standard expected at Mt Herbert House.</p> <p>Formal monitoring occurs through regular internal audits conducted every four months. The clinical nurse manager assigns the completion of the internal audits and these are completed by the RNs or another senior staff member. These demonstrate that the cleaning and laundry services are being completed to an appropriate standard. Satisfaction survey results confirmed that the majority of respondents are satisfied or very satisfied with cleaning and laundry services.</p>   |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>                                    | FA | <p>There is an emergency management plan for civil defence emergencies which has been developed with the HBDHB. It incorporates a range of requirements to ensure that services can continue to be delivered at the facility.</p> <p>There are alternative energy and utility sources on site with a 2200 litre water tank and gas cylinders for cooking. Additional food supplies and equipment to respond to an emergency are maintained, and monitored to check for expiry dates. Staff members interviewed understood their responsibilities for responding to emergency situations and all have taken part in trial evacuations and fire and safety training.</p> <p>There is an approved evacuation plan (June 2003) for the facility which has been updated in April 2015 to suit the new building layout.</p> <p>MHH has a call bell system and operates appropriate security measures to ensure safety for residents and staff at all times. This is confirmed in the satisfaction survey results.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>            | FA | <p>Each bedroom, and communal rooms, have large, opening windows which face onto an outside view. Some bedrooms face onto an internal, private courtyard. All windows open and allow ventilation. All windows have adequate curtains for privacy, shade, and warmth as appropriate given the time of year.</p> <p>There is electric heating throughout the facility when this is needed. During interviews two families reported that the lounge used by hospital residents could be hot at times. The facility manager discussed balancing the different preferences and needs of all the residents for a comfortable</p>  |

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| comfortable temperature.  |    | temperature. On the days of the audit, which were hot, windows were open to promote a breeze and curtains used for shade in all communal rooms and residents' bedrooms as they choose.  |
| <p>Standard 3.1: Infection control management</p> <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> | FA | <p>Infection control management at Mt Herbert House is guided by a comprehensive infection control manual, last updated in January 2016. A second infection control manual, produced by an external provider, is also available as a resource. The service's manual includes definitions, procedures, guidelines to identify infections, information for all employees related to accidents, spills, needle stick injury prevention, sharps management and single-use items.</p> <p>One of the acting clinical manager or clinical manager in training is the designated infection control coordinator. Infection control matters, including surveillance results, are reported to the facility manager who reports to the Director. The results of the surveillance programme and any other infection control matters are shared with staff via the regular staff meetings and at staff handover meetings. This was confirmed in meeting minutes and staff interviews.</p> <p>The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. A sign at the main entrance to the facility asks anyone who is or has been unwell not to enter the facility.</p> |
| <p>Standard 3.2: Implementing the infection control programme</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>The infection control coordinator has appropriate skills, knowledge, qualifications and experience for the role. They advised that they are well supported by the service to attend regular education related to infection control and this was confirmed in their training records. The infection control coordinator is also able to use a range of established networks, such as with the infection control team at the DHB, when additional support/information is required, and has access to diagnostic results to ensure timely treatment and resolution of infections.</p> <p>There are numerous hand sanitiser dispensers around the facility, including one in each resident's room. Other protective equipment is freely available to staff, who confirmed the availability of this equipment. The service also maintains a supply of additional equipment in case of an infection outbreak (supplies sighted).</p> <p>The service has sufficient resources and expertise to accommodate an additional four residents.</p>  |
| Standard 3.3: Policies and procedures   | FA | A comprehensive policy/procedure manual guides infection prevention and control practices. These comply with relevant legislation and current accepted good practices. The manual is reviewed   |

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| <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> |           | <p>annually, with the last review being undertaken in January 2016.</p> <p>Housekeeping and kitchen staff were observed to be compliant with generalised infection control practices. Care delivery staff were observed using hand-sanitisers on a regular basis and wearing disposable aprons and gloves as appropriate.</p>   |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>   | <p>FA</p> | <p>Infection control is a component of the staff orientation programme. All staff must then attend a mandatory yearly study day, run by the DHB, which includes an infection control education programme (staff attendance records were sighted). Additional staff education is also provided on an as-required basis. There is a strong emphasis on handwashing as an infection control measure. All staff must complete handwashing competencies annually, and handwashing audits are conducted six-monthly.</p> <p>Education with residents is generally on a one-to-one basis. This may include reminders about handwashing or strategies to minimise the possibility of infections.</p>  |
| <p>Standard 3.5: Surveillance</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>   | <p>FA</p> | <p>Surveillance of an appropriate range of infections is undertaken on a monthly basis. This includes data related to urinary tract infections, respiratory, eye, gastrointestinal and skin infections. The infection control coordinator develops the monthly surveillance record, which is reported to the facility manager. The facility manager enters this data into the organisation's infection control data base, which is also reported to the director, and discussed at the fortnightly facility managers' meetings. The organisation publishes a monthly summary of infection rates across its three facilities, which can be used for benchmarking purposes.</p> <p>Surveillance data is graphed for staff on a monthly basis, reported to the next staff and health and safety meetings, discussed at handovers, and updates recorded in the communications book as required.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p>   | <p>FA</p> | <p>There is a restraint minimisation and safe practice policy and procedure for Kaylex Care. The focus is on minimising the use of restraint. Enablers are voluntary and consented to by the resident. At the</p>   |

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| <p>Services demonstrate that the use of restraint is actively minimised.</p> |  | <p>time of the audit there were no residents who had restraints in use and no residents using enablers.</p> <p>There are systems and processes for the approval, management, monitoring and quality review of restraint use within the facility, should this be required. Records were available for restraints and enablers when these have been used by residents in the past. The systems are consistent with these standards and provide for the safe use of restraints and the use of enablers which promote safety and wellbeing.</p> |
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## 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.

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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome  | Attainment Rating | Audit Evidence   | Audit Finding   |
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| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | CI                | <p>There is a comprehensive training, education and ongoing development programme in place, developed by the facility manager. This encompasses all positions at the facility. Over the past three years an annual quality plan objective has been to improve the attendance at, and completion of training and education to staff, and to maintain and improve levels of satisfaction in service delivery.</p> <p>Apart from two staff members who commenced work in December 2015, all staff at MHH have completed one or more relevant sector qualifications for their positions. For example, caregivers hold the national certificate in health and wellbeing (or similar), two staff members hold the national certificate in hauora, the full time cook and kitchen staff member have both renewed their food safety qualifications within the last two years, all nursing staff have a current professional development and recognition portfolio.</p> | <p>Continuous improvement is recognised here in training, education and ongoing development. The service has achieved beyond full attainment through a process of measurement by family members and outcomes of learning.</p> <p>Staff members interviewed during the audit all talked about the importance of the education programme for them in their roles and that they feel valued and supported by their employer.</p> <p>The annual family satisfaction survey results have increased since 2013 when the overall</p> |

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|  |  |  | response to the care provided at MHH was average, to the 2015 survey when the overall response was excellent. |
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End of the report.