

Kaylex Care (Fielding) Limited

Introduction

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

The audit has been conducted by 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 (Fielding) Limited

Premises audited: Woodfall Lodge Retirement Home

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

Dates of audit: Start date: 28 June 2016 End date: 28 June 2016

Proposed changes to current services (if any): Application has been made to the Ministry of Health to increase bed numbers by two by changing a treatment room and a bathroom into two bedrooms.

Total beds occupied across all premises included in the audit on the first day of the audit: 35

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

| Indicator | Description | Definition |
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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 |
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| | 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

Woodfall Lodge Retirement Home provides rest home and hospital level care for up to 36 residents. The facility is operated by Kaylex Care (Fielding) Limited.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and a GP.

There are two bedrooms currently being built from existing space. These rooms are small and would be adequate for rest home level care only.

The areas that required improvement from the previous audit relating to monthly reports, up to date policies and procedures, analysis of quality data, current competences for restraint, aspects of medicine management and maintenance issues have been addressed.

There are 16 areas requiring improvement from this audit. There are some that remain from the last audit and others that are new to this audit. These areas relate to effective communication with residents and families, complaint management, audit schedule and completed audits, reporting of quality data to staff, corrective actions, human resources management, staff education, resident

documentation including meeting timeframes and interventions, aspects of the food service, the physical environment and infection control surveillance.

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. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Staff demonstrated an understanding of residents' rights and obligations. Information regarding residents' rights, access to interpreter services and how to lodge a complaint was available to residents and their families. The complaints register is current up until May and all complaints for this period have been entered.

There have been two investigations completed by the Health and Disability Commissioner's advocate since the last surveillance audit.

Residents and their families reported their satisfaction with the open communication with staff.

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. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Kaylex Care (Fielding) Limited is the governing body and is responsible for the services provided. A business plan and a quality and risk management plan were reviewed. The facility manager participates in meetings held every two weeks with one of the directors via 'Skype'.

The facility manager completes a monthly report that includes a range of topics. A weekly occupancy report is also provided to head office.

The facility is managed by a facility manager/registered nurse who has been in this position for three months. The facility manager is supported by a clinical manager/registered nurse who is responsible for the oversight of the clinical services in the facility.

Clinical indicators are sent to head office by the facility manager and results reported back to the facility. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collected, collated and analysed. Graphs of clinical indicators are available for staff to view along with meeting minutes.

Documentation, including policies and procedures have been reviewed and are current.

There are policies and procedures on human resource management. In-service education was provided for staff at least monthly during 2015. Care staff reported they have completed the New Zealand Qualifications Authority Unit Standards.

A documented rationale for determining staffing levels and skill mixes is in place to provide safe service delivery. The facility manager and clinical manager are rostered on call after hours. Care staff reported there is adequate staff available.

Continuum of service delivery

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| <p>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.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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Registered nurses are on duty 24 hours each day. There are processes in place to guide continuity of care, such as the updating of resident progress notes each shift, and written and verbal handover of information between shifts.

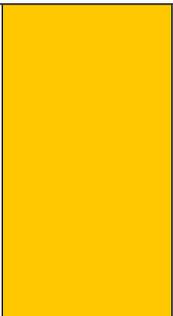
Care plans are individualised, based on a comprehensive and integrated range of clinical information and include input from residents and families.

The kitchen was well organised and maintained in a clean and hygienic manner. There was a systematic and comprehensive approach to ensuring that resident's individual nutritional needs were being met.

The residents' activity programme offers residents a variety of individual and group activities. Residents are encouraged to maintain their links with the community. Resident meetings are held monthly.

All aspects of medication management meet legislative and best practice requirements. Medications are administered by RNs who have demonstrated their competency in relation to medicines management.

Safe and appropriate environment

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| <p>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.</p> |  | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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A current building warrant of fitness is displayed. A treatment room and a bathroom are part way through being renovated to provide two bedrooms.

Restraint minimisation and safe practice

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| <p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p> |  | <p>Standards applicable to this service fully attained.</p> |
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Documentation of policies and procedures and interview of the facility manager demonstrated residents are experiencing services that are the least restrictive. There are currently no residents using restraint or enablers.

Infection prevention and control

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| <p>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.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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Infection surveillance is occurring. The results of the monthly infection surveillance reports are reported to staff at staff or health and safety meetings.

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 | 6 | 0 | 0 | 10 | 0 | 0 |
| Criteria | 0 | 24 | 0 | 1 | 15 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>PA Moderate</p> | <p>The facility manager is responsible for the management of complaints. There are appropriate systems in place to manage the complaints processes. The complaints register is not current as there are complaints that have not been entered for June 2016. Although the facility manager reported they have been responded to and meetings held with the complainants, there was no documented evidence to support this. Documentation up to May 2016 evidenced all complaints had been investigated and complainants provided with responses in a timely manner. There was evidence that complainants were satisfied with the outcome of these complaints. Staff files included documentation relating to complaints about staff.</p> <p>There have been two investigations by a Health and Disability Services advocate this year concerning the way a staff member spoke to a resident and a request for a certain type of equipment. Documentation evidenced these have been investigated, addressed and now closed. There have been no investigations by the Ministry of Health, DHB, Health and Disability Commissioner, Accident Compensation Corporation (ACC), Coroner or Police since the previous surveillance audit.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Systems are in place that ensures residents and their families are advised on entry to the facility of the complaint processes. Residents and families demonstrated an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues during these meetings. Residents and families interviewed and review of resident meeting minutes confirmed this. Review of</p> |

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| | | <p>the collated resident and family surveys evidenced residents and families knew the process for making a complaint.</p> <p>The complaint process and forms were observed to be readily accessible and displayed. Quality and staff meeting minutes evidenced reporting of any complaints is an agenda item. Care staff confirmed information was reported to them via their staff meetings.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>PA Moderate</p> | <p>The service has an open disclosure policy which guides staff relating to the principles and practice of open disclosure. Education on open disclosure has been provided and communication with relatives is documented in the residents' communication records and incident forms. Access to interpreter services is available when required.</p> <p>There is a board with staff names and designations on it for residents and families to recognise who the staff members are. Residents and families reported they do not remember who the staff are when they greet residents or family as staff are not wearing name badges. This requirement relating to staff not wearing name badges remains an area for improvement from the previous audit.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>A business plan includes goals and objectives, a mission statement, values, a vision and objectives. There are systems in place for monitoring the service and regular electronic monthly and weekly reporting is completed by the facility manager to head office.</p> <p>Woodfall Lodge is managed by a facility manager (FM) who is a registered nurse and has been in this role for three months. The facility manager is new to managing an aged care facility. Prior to this appointment, the FM held a quality/clinical position for another organisation. The facility manager has completed a course in management and leadership through the aged care association of Australia. The FM reported they have worked in the past as a RN in other aged care facilities. The facility manager is supported by a clinical manager (CM) who has been in this role for three months. The CM is experienced and prior to this appointment held a manager's position in another aged care facility. The facility manager is also supported by another facility manager within the organisation. The annual practising certificates for the facility manager and clinical manager were reviewed and are current. There was evidence in the facility manager's and clinical manager's files of education, including that relating to management.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>Woodfall Lodge is certified to provide hospital level and rest home level care. On the day of this audit there were 10 hospital level care residents and 25 rest home level care residents.</p> |

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| <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>PA Moderate</p> | <p>A quality and risk management plan is used to guide the quality programme and includes goals and objectives.</p> <p>Clinical indicators and quality improvement data was recorded on various registers in both hard copy and electronically. Quality improvement data is being collected, collated and analysed and trends identified. There have been no internal audits completed for 2016 apart from medicine management. Corrective actions are not being developed following deficits identified.</p> <p>The facility manager provides clinical indicators to head office monthly for benchmarking. Data evidenced good analysis and trending, however this information is not being reported back to staff. Quality/staff meeting minutes and staff confirmed this.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and references legislative requirements. Policies and procedures have been reviewed and provided electronically via 'drop box'. Policies and procedures and other documentation used in the facility are current.</p> <p>A health and safety manual is in place. There is a hazard reporting system available, however, health and safety meetings have not been held this year. The health and safety representative confirmed this. A hazard register identified potential health and safety risks as well as risks associated with human resources management, legislative compliance, contractual and clinical risks. Hazards were identified by the auditors during the audit, however, there was no register for actual risks/hazards available.</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>Adverse, unplanned or untoward events are documented by staff on incident/accident forms. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Family confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. Policy and procedures comply with essential notification reporting. The facility manager and the manager of another facility within the group reported there have not been essential notifications to the Ministry of Health since the last audit.</p> |
| <p>Standard 1.2.7: Human Resource</p> | <p>PA</p> | <p>The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority. Staff files sampled had reference checking, job descriptions</p> |

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| <p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>Moderate</p> | <p>and police vetting. Employment agreements have a section on confidentiality that references resident and employer information and documentation. Not all files sampled had evidence of an orientation, and current performance appraisals. These were findings at the last audit.</p> <p>The clinical manager is responsible for the in-service education programme at Woodfall Lodge. The 2015 education folder was not able to be located, however an electronic spread sheet evidenced education and current competencies for 2015. Current restraint and medicine questionnaires were evidenced. First aid certificates are current. The CM has developed an education programme for 2016 and confirmed along with staff that there has been no education provided so far this year. One of the three RNs who are interRAI trained has documentation that verifies they are currently competent.</p> <p>The infection control coordinator is the CM who has received education relating to infection control. There are new staff in the kitchen, and the staff member who has recently been employed is booked to complete education relating to food safety.</p> <p>There are policies and procedures on human resources management. Annual practising certificates for all registered nurses employed are not current. Contracted health professional had copies of current practising certificates on file.</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>There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse cover is provided 24 hours, seven days a week. On call after hours is provided by the facility manager and clinical manager. The minimum number of staff on duty is during the night and consists of a registered nurse (RN) and two caregivers.</p> <p>Staff interviewed reported there is adequate staff available and that they are able to get through their work. Residents interviewed reported staff provide them with adequate care. Observations during this audit confirmed adequate staff cover is provided. The FM and CM advised they are currently reviewing the roster with input from staff to better utilise the hours provided.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with</p> | <p>FA</p> | <p>All aspects of medication management were consistent with legislative requirements and safe practice guidelines, as evidenced by electronic records, documentation, observation and interview.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Staff who administered medicines were competent to perform the function they managed.</p> <p>Controlled drugs are stored in a separate locked cupboard. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidenced weekly and six monthly stock checks and</p> |

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| <p>current legislative requirements and safe practice guidelines.</p> | | <p>accurate records.</p> <p>The records of temperature for the medicine fridge had readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date were recorded electronically on the commencement and discontinuation of medicines. Resident allergy status was recorded, and medication administration records were complete.</p> <p>The RN advised that medications were checked against the medication chart by a RN on arrival to the service. All medications in the medication trolleys and stock cupboards were within current use date. The date of first use of eye drops was recorded on those products currently in use. Surplus and expired medication was returned to the pharmacy.</p> <p>There were no residents' who self-administer their medicines on the day of audit, however appropriate processes are in place to ensure this is managed in a safe manner, should it occur.</p> <p>Medication errors were reported to the RN and recorded on an incident form. The resident and/or the designated representative were advised. There was a process for comprehensive analysis and management of any medication errors, and compliance with this process was verified.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>PA Moderate</p> | <p>The food, fluid and nutritional requirements of the residents are provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented May 2016 assessment of the planned menu. An interview with the recently appointed cook confirmed past experience in a similar role and qualifications in advanced food safety. The kitchen assistant has had no training on food safety (refer 1.2.7.5), however the FM verified this has been booked.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements were known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted. There was an effective and systematic approach to ensuring that residents' weights were carefully monitored monthly and followed up when a concern arises.</p> <p>The effectiveness of chemical use, cleaning, and food safety practices in the kitchen was monitored by an external provider. The facility received monthly reports and recordings on the effectiveness of the programme.</p> <p>The kitchen on inspection was clean. Food in the fridge and freezers was dated and covered. Fridge and freezer temperatures were monitored with temperatures recorded within the required range. Some aspects of food storage, preparation and disposal are requiring attention.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes. A resident expressed a recent incident of meal dissatisfaction</p> |

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| | | <p>and this has been addressed (refer 1.3.3).</p> <p>There was sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed. The dining rooms were clean, warm, light and airy to enhance the eating experience.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>PA Moderate</p> | <p>RNs are on duty at all times to provide guidance and direction to care staff to support residents having their needs met. Interviews with residents verified the provision of care provided was consistent with residents' needs and desired outcomes. Processes are in place to ensure continuity of care. An interview with one of many GPs confirmed satisfaction with the standard of care provided to residents.</p> <p>Documentation in files reviewed does not identify the required support the resident requires to address their needs. This was verified by interview with the CL, RN and care staff. The CL identified inconsistency in the care plan format operating within the facility. There is a plan to align the interRAI assessment with the interRAI care plan.</p> <p>Residents and family/whanau members expressed satisfaction with the care provided; however, concern was expressed around staff leaving and staff dissatisfaction with recent changes.</p> |
| <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> | <p>FA</p> | <p>The person responsible for resident activities was absent and unable to be interviewed on the day of audit. Documentation and interviews verified residents are assessed on admission to ascertain their previous and current interests, needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matched the skills, likes, dislikes and interests evidenced in assessment data.</p> <p>The residents' individualised activity plan was reviewed as part of the care plan.</p> <p>Documentation and interviews verified activities reflected residents' goals, ordinary patterns of life and included normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.</p> <p>A residents' meeting was held monthly. Meeting minute's evidence the activities programme was discussed. Interviews verified satisfaction with the activities programme. Feedback is sought on satisfaction with the activities offered.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service</p> | <p>PA Moderate</p> | <p>The RN is responsible for the evaluation of residents' progress towards previously identified goals, as verified by documentation, observation and interviews. Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> |

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| <p>delivery plans are evaluated in a comprehensive and timely manner.</p> | | <p>A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Documentation and interviews, verified residents and family/whanau were included and informed of all changes. There is no documented evidence to indicate the degree of response to interventions implemented in either the short term care plan or the lifestyle care plan</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>PA Moderate</p> | <p>A current building warrant of fitness is displayed that expires on the 5 May 2017. There have been no structural alterations since the last audit. The tap over the sink in the kitchen has been replaced.</p> <p>Free standing oil filled heaters continue to be used in passageways and in residents' rooms. Although an external company has been engaged to undertake the servicing of the under floor heating system, the facility manager reported they are still waiting for this to happen. The FM reported at present the under floor heating is heating some areas too warmly and other areas not warmly enough.</p> <p>The FM advised an application has been lodged with the Ministry of Health to increase the bed numbers by two. This is to be achieved by renovating an existing treatment room and a bathroom. These rooms are partly renovated, they are small and adequate for rest home level care only. The rooms look out to a concrete block wall and one room's window is opposite the vented housing for the commercial drier in the laundry. When the window is open there is significant noise from the drier and lint was observed coming through the window.</p> <p>There is clutter covering the decking from the two rooms opposite. A bath is partly blocking the ramp which is a designated exit should there be an emergency.</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>PA Moderate</p> | <p>Surveillance of infections (respiratory, skin, soft tissues, urinary tract, gastrointestinal and multidrug resistant infections) is occurring and is the responsibility of the infection control nurse.</p> <p>Incidents of infections and the required management plan is presented daily at handover, to ensure early interventions. No analysis is being undertaken to identify possible causes or actions that could be implemented to reduce infection rates. Monthly surveillance data is collated and figures presented at health and safety and staff meetings.</p> <p>Meeting minutes and interviews verified data was presented and corrective actions discussed and implemented.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> | <p>FA</p> | <p>The definition of restraint and enablers meets the standard. There were no residents using restraint or enablers and the facility manager advised restraint has not been used for a number of years. Staff were able to describe the</p> |

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| Services demonstrate that the use of restraint is actively minimised. | | process should restraint be required. |
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|---|---------------------------|---|--|--|
| <p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p> | <p>PA</p> <p>Moderate</p> | <p>The complaints register is current up to the end of May 2016.</p> <p>Documentation evidenced complaints have been managed and complied with Right 10 of the Code including satisfaction of the complainants.</p> <p>Where there had been a complaint about a staff member, this was on file.</p> <p>Complaint forms are accessible for residents and families and complaint processes are part of the admission process for residents. Residents, families and staff demonstrated an awareness of complaint processes.</p> <p>There are two complaints for June 2016 and these have not been entered into the complaints register.</p> | <p>Complaints for June 2016 have not been entered into the complaints register and there was no documented evidence that these complaints have been managed as required.</p> | <p>Provide evidence that the complaints register is up to date and that the management of the two complaints in June 2016 is documented and held on file.</p> <p>90 days</p> |

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| | | The facility manager reported these two complaints have been responded to within the timeframes required and meetings have been held with the complainants. However, there was no documented evidence available. | | |
| <p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p> | <p>PA</p> <p>Moderate</p> | <p>A board has been attached to the wall in the passage way that links the two areas. This has photos of the staff and their positions. Residents, families and staff reported this has been done to address the issue from the last audit of staff not wearing name badges. They also reported this has not helped at all as residents in particular want to see the name of the staff member when they enter their room. Residents and families reported they do not remember who the staff member is by looking at a photo on a board. Staff were not wearing name badges on the day of the audit.</p> | <p>Staff are not wearing name badges to enable residents and families to identify them when they enter a resident's rooms and when carrying out personal cares.</p> | <p>Improve identification of staff members for residents and families.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p> | <p>PA</p> <p>Moderate</p> | <p>Clinical indicators and quality improvement data was recorded in both hard copy and electronically. Quality improvement data is being collected, collated and analysed and trends identified. Apart from medicine management, there have been no internal audits completed for 2016, the last audits were completed in December 2015. Medication management has not been included in</p> | <p>Apart from a medicine management audit, there have been no audits completed for 2016. The audit programme for 2016, does not include medicine management.</p> | <p>Implement the audit programme and include medicine management in the programme.</p> <p>90 days</p> |

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| | | the audit programme for 2016. This was a requirement at the previous audit. | | |
| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | PA Low | Quality data is collected and collated and sent to head office by the FM on a monthly basis. Data evidenced analysis and trending, including graphs and this information is being reported back to the facility. However, quality/staff meeting minutes do not document this information is reported back to staff. The FM and staff confirmed this. | Meeting minutes reviewed and staff confirmed quality data is not being reported back to staff at quality/staff meetings. | <p>Provide documented evidence that quality data is reported back to staff on a regular basis.</p> <p>180 days</p> |
| <p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p> | PA Moderate | There was some evidence of recommendations, when deficits were identified, however, there was no evidence of any follow up for effectiveness. Corrective action plans are not being developed and implemented. This remains a requirement from the previous audit. | Corrective actions are not being developed and implemented following any deficits identified. | <p>Provide evidence that corrective actions are developed and implemented and reviewed for effectiveness.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored,</p> | PA Moderate | Potential hazards/risks are identified and documented. However, actual risks identified are not recorded and there is no register available. There was no evidence of monitoring, analyses, evaluation and review. Actual risks were observed by the auditors during this audit. There has not been a health and safety meeting | Actual risks are not being documented and there is no evidence of monitoring, analysis, evaluation and review. | Provide documented evidence that actual hazards/risks are documented, monitored, analysed, evaluated and |

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| analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | | held this year. This was confirmed by the health and safety representative. | | reviewed. 90 days |
| Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Moderate | Allied health professionals had evidence of current practising certificates held on file. Four of the seven registered nurses employed did not have a copy of their current practising certificate on file. | Four of the seven registered nurses did not have a copy of their current practising certificate on file. | Provide evidence at all health professionals both employed and contracted have a copy of their current practising certificate on file. 90 days |
| Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | Staff files sampled had completed application forms, reference checks, police vetting, job descriptions and signed employment agreements. Three of the seven staff files have no evidence of current performance appraisals. | Three of the seven staff files sampled do not have current performance appraisals. | Provide evidence that all staff have a current performance appraisal. 90 days |
| Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of | PA Moderate | Staff interviewed reported they had received an orientation. The orientation programme provided covers the essential components of the service provided. Orientation is | Five of the seven staff files reviewed have no evidence of an orientation. | Provide documented evidence that all new staff have an orientation. |

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| the service provided. | | completed over three months. Five of the staff files do not have a copy of the orientation on file. This remains a requirement from the previous audit. | | 90 days |
| <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> | PA Moderate | <p>The CM has developed an education programme for 2016. There has not been any in-service education provided so far this year. The CM and staff confirmed this. The 2015 education folder was not able to be located, however an electronic spread sheet evidenced education and current competencies for 2015. Restraint and medicine questionnaires were evidenced and current. First aid training is current. One of the three RNs who are interRAI trained has documentation that verifies they are currently competent.</p> | <p>Although the CM has developed an education programme for 2016, there has not been any in-service education provided so far this year. Two of the three RNs who are interRAI trained have no evidence of current competency.</p> | <p>Implement the in-service education programme. Evidence that all the RNs who are interRAI trained are currently competent.</p> <p>90 days</p> |
| <p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p> | PA Moderate | <p>The kitchen on inspection was clean. Food in the fridge and freezers was dated and covered. Fridge and freezer temperatures were monitored with temperatures recorded within the required range. The temperature of the meat after cooking was not consistently recorded.</p> <p>Decanted foods, recorded the dates they were decanted however the use by date was unknown. Some items had been decanted over a year.</p> <p>No evidence was sighted of a cleaning</p> | <p>Some aspects of food preparation around the recording of cooked meat temperatures, storage of decanted foods and disposal of cooked food waste are not compliant with current legislation and guidelines.</p> | <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.</p> |

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| | | <p>regime and there was no verification it has been complied with.</p> <p>Untreated cooked food waste, is supplied to a person to feed pigs. There is no assurance to verify the person will treat the food waste according to the Ministry for Primary Industries guidelines before it is fed to the pigs.</p> | | 90 days |
| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | <p>PA Moderate</p> | <p>Sighted documentation, observation during audit and interviews with the facility manager and clinical leader, documentation verifies that residents' initial assessments and care plans are completed within 24 hours of admission, yet ongoing assessments and care plan updates in four of the five files reviewed are not completed every six months.</p> <p>Residents are routinely reviewed by the GP three monthly, however in three files reviewed there is no record the GP has verified the resident is stable and does not require monthly reviews.</p> <p>The medication management system operates electronically, yet on the day of audit eight of 32 medication charts had no updated three monthly medication reviews recorded, despite numerous requests by the RN for the GPs to do so.</p> | <p>Ongoing assessments and care plan updates are not consistently completed every six months, residents are not verified by the GP as suitable for three monthly reviews and medication reviews are not documented to be occurring three monthly.</p> | <p>Evidence demonstrates that the services provided are within the required timeframes.</p> <p>90 days</p> |

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| <p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p> | <p>PA Moderate</p> | <p>Processes were in place to ensure continuity of care. The RN guides and directs all care staff to support residents. Documentation in the care plans however, does not describe the support required to meet residents' needs e.g. behaviour management, anti-coagulant management and diabetes management. At times the required support e.g. monitoring of fluid input and regular blood pressure recordings was not evidenced to have been provided. This was verified by interviews, observation and documentation.</p> | <p>Documentation in the care plan did not describe the support the resident required to address the resident's needs.</p> | <p>Provide evidence that services provided to residents are consistent with meeting their assessed needs.</p> <p>90 days</p> |
| <p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p> | <p>PA Moderate</p> | <p>Resident care was evaluated every shift and any changes reported to the RN. Short term care plans were not observed to have been evaluated to determine if the desired outcome had been achieved e.g. effectiveness of management strategies implemented for urine and skin infections. Evaluation of the lifestyle care plan was not evident in four files reviewed e.g. effectiveness of strategies for the management of heart failure, diabetes and falls. This was verified by the RN and CL at interview.</p> | <p>Care plans did not indicate the degree of response to the interventions being provided</p> | <p>Evidence is provided of evaluations being documented to indicate the degree of response to the intervention provided.</p> <p>90 days</p> |
| <p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility,</p> | <p>PA Moderate</p> | <p>Free standing oil filled heaters were observed still being used in passageways and in residents' rooms. These heaters are hot to touch and</p> | <p>Free standing oil heaters are still being used to heat areas where the underfloor heating is not efficient. These heaters are hot to touch and</p> | <p>(1) Either replace the existing oil heaters for a safer means of</p> |

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| <p>aids independence and is appropriate to the needs of the consumer/group.</p> | | <p>are not secured. Some of the cords had been shortened, but others were long enough to cause a risk to residents. The facility manager reported the heaters were still in place because some areas were not warm enough. The FM advised a specialist company has been engaged to undertake servicing of the underfloor heating and they had been advised this job was on the company's urgent list. However, the system has still not been serviced.</p> <p>A treatment room and a bathroom have been partly renovated to provide two more bedrooms. They are small in size and the window in one of the rooms looks out to a concrete block wall and is opposite the vented housing for the commercial drier in the laundry. When the window is open there is significant noise from the drier and lint was observed coming through the window.</p> <p>There is clutter covering the decking from renovating the two rooms opposite. A bath is partly blocking the ramp which is a designated emergency exit.</p> | <p>most of the electric cords are still long enough to be a risk to residents. The two proposed bedrooms have a window that looks out to a concrete block wall and one bedroom is opposite the vented housing for the commercial drier located in the laundry. There is significant noise from the drier and lint was observed going through the window. The decking opposite the two part renovated rooms is full of clutter and a bath is blocking the emergency exit.</p> | <p>heating or make the oil heaters safe to use. (Timeframe 30 days)</p> <p>(2) De-clutter the decking and remove the bath blocking the emergency exit. (prior to occupancy).</p> <p>(3) Provide evidence that the proposed new bedrooms both have a window that provides a view and that the noise made and lint created by the drier when in use is eliminated. (Prior to occupancy).</p> <p>Prior to occupancy days</p> |
| <p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted</p> | <p>PA Moderate</p> | <p>Increases in infections captured in surveillance data, had no analysis undertaken to identify possible causes. Interview with the FM confirmed the analysis of surveillance data is not occurring. Meeting minutes</p> | <p>Analysis of surveillance data to identify any significant trends, possible causative factors and required actions, is not occurring.</p> | <p>Results of surveillance are analysed, and any conclusions and recommendations</p> |

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| <p>upon, evaluated, and reported to relevant personnel and management in a timely manner.</p> | | <p>have no documentation supporting analysis findings and specific recommendations to assist in infection reduction.</p> | | <p>to achieve infection reduction are acted on.</p> <p>90 days</p> |
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.