

# Ki-Chi Service Supplies Company Limited

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## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Ki-Chi Service Supplies Company Limited
<b>Premises audited:</b>	Raglan Trust Hospital and Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services – Sensory
<b>Dates of audit:</b>	Start date: 16 August 2016 End date: 17 August 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	27

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

Raglan Trust Hospital and Rest Home provides rest home and hospital level care for up to 36 residents. On the day of the audit, there were 27 residents. A facility manager, with support from a clinical nurse leader, manages the service. The residents and relatives interviewed spoke positively about the care and support provided.

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

The service has addressed four of eight shortfalls from the previous certification audit. The areas addressed included maintenance of a complaints register, pain assessments, monitoring of medication fridge temperatures and an updated fire evacuation plan. Improvements continue to be required around implementation of the quality systems and restraint use.

This surveillance audit identified a number of moderate risk findings in relation to advanced directives, policies and procedures, meetings, internal audits, human resource management, education, care planning, interventions, food temperatures, and infection control. A high-risk finding has been identified around the lack of quality and risk management programme.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Residents and families interviewed report that they are kept informed. Residents and their family/whānau are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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A facility manager and clinical nurse leader are responsible for the day-to-day operations of the facility. Quality and risk management processes are documented. A health and safety plan is documented.

Residents receive services from suitably qualified staff. Human resources processes are documented. An orientation programme is in place for new staff. An education plan is documented.

Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the GP and visiting allied health professionals.

An activities programme is provided for the residents that is varied, interesting and involves the families/whānau and community.

Medication policies comply with legislative requirements and guidelines. Registered nurses and care staff responsible for administration of medicines complete education and medication competencies.

All meals are prepared on site. Fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents, family/whānau interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is in a visible location.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The service has appropriate procedures and processes documented for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents using enablers and five residents assessed as requiring the use of restraint.

## Infection prevention and control

<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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The infection control surveillance programme is appropriate to the size and complexity of the service.

## 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	10	0	4	7	1	0
<b>Criteria</b>	0	34	0	8	12	1	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 1.1.10: 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>	PA Low	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the six resident files reviewed (two rest home, three hospital – including one resident under 65 admitted under the residential disability certification and one respite resident). Care staff interviewed, confirm consent is obtained when delivering cares. Resuscitation orders had not been appropriately signed by the resident and general practitioner in the files reviewed.</p> <p>Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives. Six admission agreements sighted were signed.</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>The service has a complaints policy that describes how complaints are managed and aligns with the requirements set by the Health and Disability Commissioner (HDC). Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with five residents (three rest home and two hospital) and five family members (two rest home and three hospital) confirmed that they understand the complaints process. They also confirmed that the managers and staff are approachable and readily available if they have a concern.</p> <p>Six complaints have been lodged since January 2016. One complaint has been lodged with the Health and Disability Commission and is still under investigation. The complaints register, commenced in January 2016,</p>

		<p>included information and correspondence related to each complaint received since January 2016. Timeframes for responding to each complaint were met and five of six complaints have been resolved. The previous audit finding relating to the complaints register has been met.</p> <p>The management of complaints by the service is not clearly linked to the quality and risk management programme and complaints are not being collated to identify any possible trends (link 1.2.3.6).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Eight accident/incident forms were reviewed. Evidence of communication with family/whānau is documented on the accident/incident forms and in the residents' progress notes. Residents and families interviewed advised that communication from the staff is respectful and easily understood and they are kept informed about changes in the resident's health status.</p> <p>There is an interpreter policy and contact details of available interpreters. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for not covered by the agreement.</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>	PA Low	<p>Raglan Rest Home and Hospital provides care for up to 36 residents across three service levels (hospital [medical and geriatric], rest home, and residential disability services – sensory). On the day of the audit there were 15 hospital level residents - including two residents under 65 (residential disability contracts), and nine rest home residents. There was one resident admitted under the acute mental health and addiction services contract and two residents admitted for respite care.</p> <p>A business/quality action plan has been documented for 2015 to 2017; however, this has not been implemented or reviewed. The manager meets weekly with the owner to discuss operational issues.</p> <p>The manager is a registered nurse with a current practising certificate who has been in the role since April 2016. The manager has previous aged care facility management experience. A clinical nurse leader supports the manager. The clinical nurse leader was previously a registered nurse at the facility and commenced the clinical nurse leader position in May 2016. The manager and clinical nurse leader have maintained over eight hours of professional development activities related to managing an aged care service in the past year.</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>PA High</p>	<p>The facility is owned and operated by Ki-Chi Service Supplies Company Limited. The service has a business relationship with the Cavell Group, and uses the Cavell Group policies and procedures to support good practice and adherence to the relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control schedule is in place. All managers of the Cavell Group regularly review policies every one-two years unless changes occur more frequently.</p> <p>Interviews with the facility manager and staff reflect an understanding of the quality and risk management systems that is required. However, documentation reviewed does not reflect an implemented quality and risk management system.</p> <p>Aspects of quality data is collected and collated, but this is not consistently completed. A number of shortfalls have been identified around the lack of an implemented quality programme.</p> <p>Falls prevention strategies are in place on a case-by-case basis, which includes the use of sensor mats and utilisation of physiotherapy services. The service has a high incidence of falls, however there was no evidence of a falls reduction strategy for the service.</p> <p>Staff interviewed were able to describe the principles of hazard management. The Cavell Group health and safety system has not yet been fully implemented.</p> <p>The previous audit findings related to quality and risk data and corrective action plans has not been resolved.</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>PA Moderate</p>	<p>Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. The resident is reviewed by the RN at the time of the event. Eight incident forms were reviewed and all were completed appropriately (link 1.2.3.6). There was evidence that the families were notified of the incidents. The events were also documented in the residents' progress notes, however the interventions required for acute changes were not documented in a care plan (link 1.3.5.2) and the required monitoring was not always evidenced (link 1.3.6.1). There were shortfalls around the documentation of incident/accident forms for pressure injuries.</p> <p>Discussions with the facility manager and clinical nurse leader confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. The owner advised (at the exit interview) a notification had been made to Worksafe but this notification could not be located (link 1.2.3.9).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	<p>PA Moderate</p>	<p>There are human resource management policies available. This includes recruitment, selection, orientation and staff training and development. The service has an orientation programme in place. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioners practising</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>certificates including GP, pharmacist and physiotherapist.</p> <p>Six staff files were reviewed (facility manager, clinical nurse leader, two caregivers, one cook and one activities staff member). All included evidence of the recruitment process, and signed employment contracts. Not all staff files sampled evidenced completed orientation documentation, signed job descriptions and annual performance reviews.</p> <p>The in-service education programme has not been implemented. The facility manager and registered nurses are able to attend external training, including sessions provided by the local DHB. One of six registered nurses has completed InterRAI training and another registered nurse is booked to attend InterRAI training next week.</p> <p>There are implemented competencies for registered nurses including (but not limited to) medication and syringe driver. There are implemented competencies for care staff for manual handling.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. At least one registered nurse is on site at any one time. Activities staff are available five days a week. Extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p> <p>There has been no reduction in staffing levels (including the RN hours) since December 2015.</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>Twelve medication charts were reviewed (four rest home, six hospital). There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided (link 1.2.7.5). Staff were observed to be safely administering medications. Registered nurses interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There were no residents self-medicating on the day of audit. There is no stock medication.</p> <p>All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.</p> <p>The medication fridge temperatures are recorded regularly and these are within acceptable ranges. The previous audit findings relating to medication fridge temperatures has been met.</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 Low</p>	<p>All meals at Raglan Trust Hospital and Rest Home are prepared and cooked on site. There is a food services manual in place to guide staff. There is a four weekly seasonal menu. Meals are delivered to the dining area.</p> <p>A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident surveys allow for the opportunity for resident feedback on the meals and food services (link 1.2.3.8). Residents and family members interviewed were satisfied with the variety of food offered but voiced concern that the hot food was not always hot. Residents confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded weekly. End cooked food temperatures are not recorded.</p> <p>Not all food services staff have completed training in food safety and hygiene and chemical safety (link 1.2.7.5).</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>Files sampled indicated that all appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six monthly or when there was a change to a resident's health condition. The InterRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Care plans sampled were not all developed on the basis of these and other clinical assessments (link 1.3.5.2).</p> <p>Evidence of regular pain assessments were found in the files reviewed and the outcome of the pain management interventions were evaluated in the progress notes. The previous audit finding related to pain assessments has been addressed.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service</p>	<p>PA Moderate</p>	<p>This standard was opened in this surveillance audit due to the number of gaps in the resident care plans reviewed. The RNs are responsible for all aspects of care planning. The care plans reviewed demonstrated service integration and input from allied health. Not all care plans included specific interventions for all identified care needs. Interventions noted in the progress notes were not transferred to the care plans. Care plans were not always documented to reflect acute changes in health status. Family/whānau members interviewed confirmed the care delivery and support by staff is consistent with their expectations.</p>

delivery.		
<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>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation (link 1.3.3.3). The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.</p> <p>In the residents' files reviewed short-term care plans not were commenced with a change in heath condition (link 1.3.5.2). Long-term care plans did not always evidence interventions documented in sufficient detail (link 1.3.5.2).</p> <p>Continance products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required. Staff interviewed could describe the components of appropriate Tikanga Māori and the components of safe cultural care.</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>An activities coordinator is employed 25 hours per week to coordinate the activities programme for all residents. Five hours of this time per week is allocated to giving out the afternoon tea. The activities coordinator is supported by another staff member who works up to 3 hours per week. The programme runs Monday to Friday and an activities table is left prepared for activities over the weekend.</p> <p>Activities are planned that are appropriate to the functional capabilities of residents. There is a weekly programme that is posted on the residents' noticeboard. The programme covers a variety of activities such as newspaper reading, discussion groups, quizzes, bowls, bingo, chair exercises, craft programmes and outdoor walks.</p> <p>There are van outings planned once a week. The activities coordinator who goes out in the van does not have a have a current first aid certificate (link 1.2.7.5). Church services are held weekly. Special occasions and birthdays are celebrated.</p> <p>For residents who have difficulty participating or who don't like to leave their rooms, the activities coordinator visits and offers books and movies.</p> <p>The resident's individual activity plan identifies activities and community links that reflect the resident's normal pattern of life. Not all resident's activity plans have been reviewed six monthly (link 1.3.8.2). Residents have the opportunity to verbally feedback on the programme.</p> <p>Residents and families interviewed report satisfaction with the activities programme.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>In the residents' files reviewed, all initial care plans were documented and evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed at least six monthly or earlier for any health changes. The GP reviews the residents at least three monthly or earlier if required. Evidence of three monthly GP reviews were seen in all resident files sampled. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes (link 1.3.3.3). Not all activity care plans in the files sampled had been reviewed at least six monthly.</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>A current building warrant of fitness is posted in a visible location (expiry 27 April 2017). The facility has a mixture of radiator heating, panel heaters and heat pumps. The residents and staff interviewed felt the facility heating was adequate to maintain a comfortable ambient temperature.</p>
<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>	<p>FA</p>	<p>The DHB requested elements of the cleaning service were audited at this surveillance audit. There are dedicated cleaning staff who work over the 7 days per week. The cleaning staff have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme (link 1.2.3.7). Residents interviewed were satisfied with the standard of cleanliness in the facility. The facility appeared clean on the day of audit.</p> <p>Care staff rostered on all shifts complete all laundry on site in an appropriately appointed laundry. The care staff interviewed advised that at times they felt they did not have enough hours allocated to complete the laundry and to provide cares. The service is currently reviewing the staffing of the laundry. The staff interviewed advised that soiled linen is put into buckets or linen skips and promptly removed to the laundry. Residents interviewed advised they are satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	<p>FA</p>	<p>Emergency and disaster policies and procedures are in place. A fire evacuation drill was last completed in August 2016. The orientation programme and mandatory education and training programme includes fire and security training (link 1.2.7.5). Staff interviews confirm their understanding of emergency procedures. Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. An approved fire evacuation plan dated 31 May 2015 was sighted. The previous audit finding related to the approved updated evacuation plan has been met.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency</p>

situations.		<p>including food, water, blankets and gas cooking. A back up three-hour battery for emergency lighting is in place.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Residents interviewed advised that their call bells were answered promptly. There is a minimum of one person who is available 24 hours a day, seven days a week with a current first aid/CPR certificate (link 1.2.7.5).</p> <p>External lighting is adequate for safety and security. Security cameras are placed in strategic locations throughout the facility with a large monitor in the manager's office.</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>Policies and procedures document infection prevention and control surveillance methods. Infection control surveillance data is collected for respiratory infections, urinary tract infections, multi-resistant organisms, eye infections, antibiotic use and diarrhoea. Surveillance data is not consistently documented. The surveillance data collected is not consistently analysed or trended. Where areas for improvement are noted no corrective action plans are documented. Infection control internal audits have not been completed. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>There have been no outbreaks since the previous audit. The infection control systems that are documented are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are restraint minimisation and safe practice policies available to the service. Guidelines on the restraints policy ensure that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register. There are currently five hospital residents using restraint (two bedrails, two tub chairs, and one chair restraint) and no residents with enablers.</p> <p>Documentation was reviewed for all residents using a restraint and evidences assessment, authorisation, and consents are in place. There has been no staff training on restraint minimisation or challenging behaviours in the past 12 months (link 1.2.7.5).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Moderate</p>	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. There is an assessment form/process that is completed for all restraint and enabler use. All resident files using a restraint were reviewed and evidenced an assessment, signed consent and regular review of the use of the restraint. Not all restraint care plans included specific interventions to manage the risk or evidenced that the monitoring was completed at the</p>

		frequency determined by the risk level and organisational policy. Staff report that they regularly check on residents while restraint is in use but this is not being documented on the restraint monitoring forms. The previous findings relating to the use of restraint have not been resolved.
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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 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	PA Low	The facility manager advised that the GP undertakes a medical review of the resident and then discusses resuscitation with the resident and or family/EPOA. The GP then documents the outcome of this discussion on the resuscitation/advanced directive form. Not all resuscitation/advanced directive status forms had been fully completed.	<p>Four of five advanced directive forms were not completed fully and did not evidence discussion on resuscitation with the resident or family/EPOA.</p> <p>Four of five advanced directives where the resident was deemed to be competent were not signed by the resident.</p>	<p>Ensure that all advanced directives are fully completed and appropriately signed.</p> <p>90 days</p>
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly</p>	PA Low	The service has a business/quality action plan in place for 2015 – 2017. This plan describes the direction and scope of the business and identifies	The 2015 - 2017 business/quality action plan has not been implemented or reviewed.	Ensure that the business/quality action plan is implemented

identified and regularly reviewed.		the business and quality goals. The business/quality action plan has not been implemented.		and progress against the goals is regularly reviewed.  90 days
Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.	PA Moderate	The service has a documented quality and risk management system. This system has not been fully implemented.	The documented quality and risk management plan/programme is not fully implemented.	Ensure that all aspects of the quality and risk management system are implemented.  60 days
Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.	PA Moderate	The service uses the Cavell Group policies and procedures. Not all policies and procedures have been fully implemented.	The organisational policies and procedures have not been fully implemented.	Ensure that all organisational policies and procedures are fully implemented.  90 days
Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	A monthly general staff meeting and a registered nurse meeting has recently been implemented. These meetings have not been held on a regular basis and do not evidence discussion around quality data and quality management systems. Residents interviewed advised that they provide feedback on the service to the facility manager, but have not	i) There is no evidence of staff meetings being held consistently. Where staff meetings have been held there is no evidence that quality data, trends, complaints, corrective actions and health and safety matters are discussed with staff.  ii) There have been no scheduled meetings with residents in the past 12	i) Ensure that meetings are held on a regular basis to communicate all relevant aspects of the quality management system.  ii) Ensure that

		had a resident meeting in the past 12 months.	months.	resident meetings are held on a regular basis.  90 days
<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>	<p>PA</p> <p>Moderate</p>	<p>Clinical indicator data is collected for falls, medication errors, skin tears, bruises, pressure injuries, absconding, fractures, soft tissue injury, behaviours, verbal abuse, wandering and near miss. This data is collated, however there is no analysis or evaluation of the clinical indicator data and the results are not consistently communicated to the staff or residents. Accident and incident forms have not been completed for all current pressure injuries.</p> <p>A complaint register is in place, however there was no evidence that the complaints were being analysed for trends. Registered nurse meetings were commenced in May 2016, and general staff meetings are held. There are no fixed agendas for the staff meetings and quality improvement data is not consistently communicated to staff.</p>	<p>i) The clinical indicator data is collected but not analysed, trended or evaluated.</p> <p>ii) Accident and Incident forms have not been completed for four of five residents with current pressure injuries.</p> <p>iii) Complaints are not being trended and analysed.</p> <p>iv) Information related to clinical incident data is not consistently communicated to staff and where appropriate to the residents.</p>	<p>i) Ensure that all clinical indicator data is consistently collected, analysed and trended.</p> <p>ii) Ensure that all pressure injuries are reported on an accident/incident form.</p> <p>iii) Ensure that complaints are analysed for trends.</p> <p>iv) Ensure that information related to clinical indicators is consistently communicated to staff and where appropriate to the residents.</p>

				60 days
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>PA Moderate</p>	<p>The service has an annual monitoring schedule. The documented audit and monitoring schedule has not been implemented.</p>	<p>Only two care documentation audits were evidenced since February 2015. These audits did not have all sections of the audit tool consistently completed.</p>	<p>Ensure that the monitoring schedule is fully implemented.</p> <p>30 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>	<p>PA Moderate</p>	<p>The service captures quality data. Where areas requiring improvements were noted, corrective action plans were not evidenced.</p>	<p>i) No corrective action plans were sighted or remedial actions evidenced where clinical indicator data identified areas requiring improvement. The areas that were above an acceptable benchmark included falls and skin tears.</p> <p>ii) The resident food satisfaction survey completed in December 2015 identified that residents reported the meals were cold. No corrective actions had been put in place to address this and the residents interviewed reported the meals were often cold (link 1.3.13.1).</p> <p>iii) The dietitian reviewed the menu in May 2016. The review identified areas for improvement. No corrective action plan has been documented to address the required improvements.</p> <p>iv) No corrective action plans had been developed and implemented for the deficits noted in the care documentation audits completed in February 2015.</p>	<p>i-iv) Ensure that corrective actions are documented and implemented where areas are identified requiring improvement.</p> <p>30 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:  (a) Identified risks are monitored, 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.</p>	<p>PA High</p>	<p>The service has a hazard register in place, however this has not been reviewed or updated since 2013. Health and safety is covered at orientation for new staff, however staff have not had any health and safety updates in the past 12 months. There is no health and safety committee and there is no evidence that health and safety and hazard management is being discussed at the staff meetings that have been held. There was no evidence that the service was implementing hazard identification reporting or that there was any monitoring of hazards. The owner advised at the exit interview, there has been one incident reported to Worksafe since the last audit. No information was on site in relation to this incident (link 1.2.4.2).</p>	<p>i) The hazard register has not been reviewed since November 2013.  ii) There has been no health and safety updates provided to staff in the past 12 months.  iii) There is no health and safety committee and no evidence of hazards and their management being discussed at any staff meetings.  iv) There is no health and safety officer currently appointed.  v) Hazard identification reporting by staff was not evidenced and there was no evidence that health and safety matters were regularly reviewed or communicated to staff.  vi) No health and safety audits have been completed.</p>	<p>i-vi) Ensure that all aspects of the health and safety management system are fully implemented.</p> <p>30 days</p>
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	<p>PA Low</p>	<p>The owner advised at the exit interview, there has been one incident reported to Worksafe since the last audit. No information was on site in relation to this incident.</p>	<p>The owner advised that a staff member sustained an electrical burn and the matter was investigated internally and a notification sent to Worksafe. No information related to this event could be located at audit.</p>	<p>Ensure that information related to essential notifications and any corrective actions undertaken in relation to this are available on site.</p>

				60 days
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>Eight incident forms were reviewed and all were completed appropriately (link 1.2.3.6).</p>	<p>Four of five current PIs had not had an accident and incident form completed</p>	<p>Ensure all pressure injuries are documented on incident forms</p> <p>60 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>The service has an orientation programme that is completed by all new staff. Copies of the completed orientation programme were not located in all staff files reviewed.</p>	<p>Two of six staff files reviewed did not evidence completion of the orientation programme.</p>	<p>Ensure that all staff complete the organisation's orientation requirements.</p> <p>90 days</p>
<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>	<p>PA Moderate</p>	<p>An annual education planner has not been implemented. Staff have been provided with training on fire evacuation, medication management, palliative care, manual handling and skin management, and complaints and advocacy in the past 12 months. Attendance at education sessions has been low and no process is in place for staff who do not attend mandatory training. Staff have completed a questionnaire on the code of rights. The facility manager advised that other staff quizzes have been completed but these could not be located and no details could be</p>	<p>i) The annual education planner has not been implemented and could not be located during the audit. There have been five sessions in the last year (as per no. iii).</p> <p>ii) The education provided in the past 12 months does not comply with the requirements of the health and disability sector standards or the aged related resident care agreement.</p> <p>iii) Nineteen of 30 staff attended the fire evacuation training, three of 30 staff attended the complaint and advocacy training, 16 of 30 staff completed the code of rights</p>	<p>i-ii) Ensure that the annual education planner is fully implemented and that education and training is provided to meet the requirements of the health and disability sector standards and the aged related resident care agreement.</p> <p>iii) Where</p>

		<p>provided on what was covered.</p> <p>Staff who administer medication have completed medication competencies and eight staff have current first aid certificates. The clinical manager has attended training on PEG feeding and has a syringe driver competency. In the staff files sampled not all staff have had an annual performance review or have a signed job description. The activities coordinator who accompanies residents on outings, does not have a current first aid certificate.</p>	<p>questionnaire and 14 of 30 staff have completed manual handling competencies. There is no process in place to follow up staff who do not attend the compulsory education sessions.</p> <p>iv) Two of six staff working in the kitchen have not completed food safety training.</p> <p>v) The activities coordinator takes residents on outings but does not have a current first aid certificate.</p> <p>vi) Three of six files sampled had no evidence of an annual performance review.</p> <p>vii) One of six files sampled had no signed job description and there was no signed job description sited for the restraint coordinator.</p>	<p>attendance is low at education, implement a system, to follow up staff who do not attend.</p> <p>iv) Ensure that all staff who work in the kitchen have completed the necessary food safety qualifications.</p> <p>v) Ensure that the activities coordinator has a current first aid certificate.</p> <p>vi) Ensure that all staff have an annual performance review.</p> <p>vii) Ensure that all staff and the restraint coordinator have a signed job description on file.</p> <p>90 days</p>
Criterion 1.3.13.1	PA Low	The registered nurse is responsible	Food temperatures are not being	Ensure that food

<p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>		<p>for completing the nutritional profile for the resident and providing this to the kitchen. The service has had the four weekly menu reviewed by a dietitian in May 2016. Fridge and freezer temperatures are recorded but no end cooked food temperatures are taken.</p>	<p>recorded and the service does not have a food temperature probe.</p>	<p>temperatures are taken and food is maintained and served to the residents at the correct temperature.</p> <p>60 days</p>
<p>Criterion 1.3.3.3 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>The registered nurse completes initial assessments and an initial care plan on admission. In the files sampled InterRAI assessments were completed for all residents requiring an InterRAI assessment. The respite care file reviewed evidenced assessments and care plans were completed within the required timeframes. Long-term care plans were completed, but not all long-term care plans had been completed within 21 days of admission. The registered nurses are responsible for all aspects of care provision. Timely follow-up by a registered nurse following an acute change in health condition was not always evidenced.</p>	<p>i) Two of five long-term files reviewed (one hospital and one rest home) did not have the long-term care plans developed within three weeks of admission.</p> <p>ii) There was no evidence of timely ongoing follow-up by a registered nurse, for a) one hospital resident who was noted to be drowsy and difficult to rouse. There was no evidence of a review by registered nurse until 12 hours later after the incident was noted in the progress notes; b) one hospital resident with a history of GI bleeds was reported by the care staff to have fresh blood in his stool, and was referred to the GP by the registered nurse. There was no documented evidence of a regular review by a registered nurse until he was seen by the GP; and c) one hospital resident had an episode of choking noted in the progress notes, and there was no evidence of a review by the registered nurse until fourteen hours after the event was</p>	<p>i) Ensure that the long-term care plan is completed within the required timeframes.</p> <p>ii) Ensure there is timely follow-up by a registered nurse for all acute changes in health condition.</p> <p>60 days</p>

			reported.	
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The long-term care plans are developed on the basis of the InterRAI and other clinical assessments. Not all long-term care plans were available on the first day of audit. Care interventions required for acute changes in health condition, although documented in progress notes, were not always transferred to a care plan.</p>	<p>i) One rest home resident with complex care needs did not have a care plan on site on the first day of audit, as a registered nurse had taken the care plan home to work on. The care plan was returned the next day.</p> <p>ii) Interventions documented in the progress notes were not transferred to a care plan in three files reviewed; (i) a rest home resident with acute vomiting, (ii) a hospital resident following a choking episode, and (iii) a hospital resident with fluid overload.</p> <p>iii) Five of six files reviewed (three hospital and two rest home) did not have care plans documented for acute changes in health condition (infections, pain management, wandering, challenging behaviour and a change in renal function).</p> <p>iv) Interventions were not documented to manage infections as reported in the surveillance data for the month of April, June and July.</p> <p>v) Interventions to guide care staff on the specific interventions to manage the pressure injury risk were not fully documented for three residents with pressure injuries.</p> <p>vi) All six files reviewed did not have sufficient detail in care plans to guide</p>	<p>i) Ensure that resident care plans remain on site and are available for all care staff.</p> <p>ii) Ensure interventions documented in the progress notes are transferred to the care plan.</p> <p>iii-iv) Ensure care plans are documented for all acute changes in health conditions.</p> <p>v-vi) Ensure care plan interventions include sufficient detail to guide staff.</p> <p>60 days</p>

			care staff in the management of all assessed care needs.	
<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>Care plans reviewed identified interventions were not always documented in sufficient detail. While monitoring charts were being utilised, care plans did not always guide staff around completing them. Not all required monitoring was fully documented.</p>	<p>Monitoring records were not totalled daily for one rest home resident on a fluid balance chart with a recent history of dehydration and one hospital resident on a PEG feed (YPD tracer). There was lack of documented evidence to reflect that the required monitoring was completed for two rest home residents who had absconded from the service.</p>	<p>Ensure that the required monitoring occurs and is documented.</p> <p>60 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 Low</p>	<p>The long-term care plans are reviewed by the registered nurse in consultation with the resident and where appropriate the family/EPOA. Long-term care plans had been reviewed at least six monthly or earlier for any health changes. Not all activity care plans had been reviewed against the stated goals or reviewed within the required timeframes.</p>	<p>Three of six activity care plans (one hospital and two rest home) had not been evaluated against the stated goals or within the required timeframes.</p>	<p>Ensure that all activity plans are reviewed in conjunction with a review of the long-term care plan and the activity plan is reviewed against the residents stated goals.</p> <p>90 days</p>
<p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency</p>	<p>PA Low</p>	<p>The infection control officer advised there is an infection control committee, however no infection control meetings have been held.</p>	<p>No infection control committee meetings have been held and no review of the site-specific infection control requirements has been completed.</p>	<p>Ensure that the infection control committee meet on a regular basis to review</p>

with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.				the surveillance programme and the surveillance data.  90 days
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>PA Moderate</p>	<p>The infection surveillance data is recorded on a monthly infection data log. The infection data is not consistently logged. There is no analysis of the infection control data and no corrective actions documented. The infection control data is not consistently communicated to staff.</p>	<p>Surveillance data is not consistently collected, analysed and trended and the results are not consistently communicated to staff. Where the results are high, corrective action plans have not been documented.</p>	<p>Ensure that surveillance data is consistently documented and analysed and trends identified. Where the results are high or there is risk identified, ensure that corrective action plans are documented. Ensure that the results of the infection control surveillance data and the corrective action plans are communicated to all staff in a timely manner.</p> <p>60 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented</p>	<p>PA Moderate</p>	<p>Restraint care plans are documented by the registered nurse</p>	<p>i) Five of five residents on restraint did not have specific interventions</p>	<p>i) Ensure that interventions are</p>

<p>in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <ul style="list-style-type: none"> <li>(a) Details of the reasons for initiating the restraint, including the desired outcome;</li> <li>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</li> <li>(c) Details of any advocacy/support offered, provided or facilitated;</li> <li>(d) The outcome of the restraint;</li> <li>(e) Any injury to any person as a result of the use of restraint;</li> <li>(f) Observations and monitoring of the consumer during the restraint;</li> <li>(g) Comments resulting from the evaluation of the restraint.</li> </ul>		<p>and/or the restraint coordinator. Not all residents using a restraint had interventions documented in sufficient detail to guide care staff in managing the identified risks. Not all monitoring of residents using a restraint was consistently documented.</p>	<p>documented in their care plan to manage the identified risk.</p> <ul style="list-style-type: none"> <li>ii) Monitoring was not completed as required by the organisational policy for five of five residents using a restraint.</li> </ul>	<p>documented in the restraint care plan in sufficient detail to guide the care staff.</p> <ul style="list-style-type: none"> <li>ii) Ensure that monitoring of residents using a restraint is consistently documented and complies with the organisational requirements and care plan instructions.</li> </ul> <p>30 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.