# Lexhill Limited - Kaikohe Care Centre

## Introduction

This report records the results of a Provisional 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Lexhill Limited

**Premises audited:** Kaikohe Care Centre

**Services audited:** Hospital services - Medical services; Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 18 August 2016 End date: 19 August 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 43

# 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.

## General overview of the audit

Kaikohe Care Centre is certified to provide rest home, hospital and dementia levels of care for up to 61 residents. On the day of the audit there were 43 residents living at the facility. An experienced and qualified facility manager, who is a registered nurse, manages the service. Residents and family interviewed were complimentary of the service they receive.

A provisional audit was conducted to assess a prospective new owner of the facility, and to assess the status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management. The prospective owner was unavailable for interview during the audit. Communication has taken place via email.

The prospective provider has owned and operated Lexall Private Hospital and Rest Home in Auckland since 2001. A transition plan has been developed that describes management and oversight, projected occupancy, staffing, maintenance and short, medium and long-term goals. The prospective provider does not plan to make any changes to the current management team or staff. A progressive review of systems will take place that will include a gradual upgrade and/or conversion of systems as deemed necessary.

This audit identified that improvements are required around the completion of internal audits, attendance at in-services, documenting care plan interventions, medication documentation, and identification and planning for risks associated with restraint.

## Consumer rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Complaints processes are implemented and complaints and concerns are managed appropriately.

## Organisational management

Services are planned, coordinated, and are appropriate to the needs of the residents. A facility manager is responsible for the day-to-day operations of the care facility.

The prospective owner has experience in the aged care sector and has been managing an aged care service since 2001. There are no plans to make any changes to the staff or service during the first year of ownership. It is the intention that the management team will remain.

Quality and risk management processes are established. Strategic plans and quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Staff document adverse, unplanned and untoward events. The health and safety programme meets current legislative requirements. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is in place. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents’ files are appropriate to the service type.

## Continuum of service delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The care plans are resident and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall residents’ files. There is a three monthly general practitioner review. Residents interviewed confirmed that they were happy with the care provided and with communication.

Medication management policies and procedures are in line with legislation and current regulations.

Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. The kitchen is well equipped for the size of the service. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

## Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint as a last resort. Staff receive regular education and training on restraint minimisation.

## Infection prevention and control

Infections are reported by staff and residents and monitored through the infection control surveillance programme by the infection control officer (a registered nurse). There are infection prevention and control policies, procedures and a monitoring system in place. Training of staff and information to residents is delivered regularly. Infections are monitored and evaluated for trends.

## 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 | 45 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 96 | 0 | 3 | 2 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Code of Health and Disability Consumers’ Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented and care staff interviewed (three caregivers, two registered nurses (RNs), two diversional therapists) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme (link to finding 1.2.7.5). |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are policies in place for informed consent and resuscitation and the service is committed to meeting the requirements of the Code. There were signed consents on all seven resident files sampled. Advance directives were appropriately signed in the files reviewed.  Discussions with staff confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. Discussions with residents confirmed that the service actively involves their relatives in decisions that affect their lives, where they consent to this. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) office is included in the resident information pack that is provided to new residents and their family on admission. HDC advocacy brochures are also available. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.  Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service (link to finding 1.2.7.5). |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages their residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are readily available at the entrance to the facility.  Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.  A complaints register is maintained. Four complaints have been lodged in 2016 (year-to-date). All four complaints were reviewed. Evidence was sighted to confirm that each complaint had been managed in a timely manner including acknowledgement, and a comprehensive investigation.  Complaints received are linked to the quality and risk management system. They communicated to staff, evidenced in the quality/staff meeting minutes. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. A registered nurse (RN) discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly resident/family meetings. All seven residents (six rest home level and one hospital level resident) and two family members interviewed (one rest home and one dementia level) reported that the residents’ rights were being upheld by the service.  The prospective owner has been running an aged care facility in Auckland for the last 15 years and has a good understanding of consumer rights. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents’ personal belongings are used to decorate their rooms. A selection of rooms includes full ensuites (one in the hospital and one in the rest home). Privacy signage is attached to communal toilet and shower doors. One resident room is shared between two residents. Signed consent forms were sighted for residents who share rooms. Curtains are installed for visual privacy.  The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, and ensure that doors are shut when cares are being provided. Personal discussions are not held in public areas. Staff reported that they promote the residents' independence by encouraging them to be as active as possible. All of the residents and families interviewed confirmed that residents’ privacy is respected.  Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service (link to finding 1.2.7.5). |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. Māori signage is posted throughout the facility. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. There were 16 residents living at the facility who identified as Māori.  Specific Māori cultural needs are identified in Māori residents’ care plans (evidenced in two of two Māori rest home level residents’ files). Two Māori residents interviewed (rest home level) reported that their cultural needs were being met by the service.  Māori consultation is available through links with Māori community organisations. Several care staff identify as Māori. Staff education on cultural awareness begins during their induction to the service and continues annually (link to finding 1.2.7.5). Three caregivers interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service.  The prospective owner acknowledges that the community of Kaikohe is recognised as being the very heart of the culture of the Ngapuhi Iwi. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents’ care plans, evidenced in all seven care plans reviewed (two rest home level, two dementia level and three hospital level). Residents and families interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Professional boundaries and the code of conduct are discussed with each new employee during their induction to the service, evidenced in all eight staff files reviewed. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Good practice was evident. A registered nurse is available 24 hours a day, seven days a week. A general practitioner (GP) from the local medical centre visits the facility twice weekly. A general practitioner (GP) reviews residents every three months at a minimum.  Resident/family meetings are held monthly, led by the diversional therapists. Residents and families interviewed reported that they are either satisfied or very satisfied with the services received. A resident/family satisfaction survey is completed annually.  The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits (eg, infection control specialist, psychiatry for older persons (POPS), mental health and addiction services). Physiotherapy services are available as needed. A van is available for regular outings.  The GP interviewed is satisfied with the care that is being provided by the service. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a range of information regarding the scope of services provided to the resident on entry to the service, and any items they have to pay for that are not covered by the agreement. Regular contact is maintained with families including when an incident or care/health issues arises, evidenced in the 15 accident/incident forms that were randomly selected for review. Interviews with families confirmed that they are kept informed. The information pack is available in large print and can be read to residents.  Interpreter services are available through the DHB if required. The facility manager reports that this has not been necessary. Care staff are multi-lingual. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Kaikohe Care Centre provides rest home, hospital and dementia levels of care for up to 55 residents (originally the service was certified for 61 rooms but six rooms are not being used. These rooms are temporarily being occupied by Te Arirki which is a day programme for preschoolers). On the day of the audit, there were 43 residents in the care centre (21 at rest home level, sixteen at hospital level and six at dementia level). Two residents were on the young persons with disability (YPD) contract (hospital level) and one resident was on respite (rest home level). All other residents were on the aged related contract. There were no residents under the medical component.  A facility manager/RN is responsible for day-to-day operations. She has 18 years experience as in management in the aged care sector. Business goals are in place with evidence of regular reviews. The facility manager meets regularly with the owner.  The nurse manager has attended a minimum of eight hours of professional development activities related to managing an aged care facility.  The prospective provider has owned and operated Lexall Private Hospital and Rest Home in Auckland since 2001. A transition plan has been developed that describes management and oversight, projected occupancy, staffing, maintenance and short (2-3 years), medium (4-8 years) and long-term (8-12 year) goals. The prospective provider does not plan to make any changes to the current management team or staff. It has been acknowledged by the prospective provider that the facility manager has a very good understanding of the needs of the facility and will be relied upon to guide the new owner. The facility manager has agreed to continue for the foreseeable future. A progressive review of systems will take place that will include a gradual upgrade and/or conversion of systems as deemed necessary.  The prospective provider has acknowledged Kaikohe Care Centre is an established part of the community and has an active presence in the community as an aged care facility and employer. There is a Kohanga Reo on site, run by the community and the facility holds the contract to supply meals on wheels. It is the prospective owner’s plan to continue to support and work with the Kaikohe community. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The clinical nurse leader (CNL) is responsible for the care centre during the absence of the facility manager. The new owners do not plan to change this arrangement. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | A quality and risk management programme is being implemented. The facility manager oversees quality. The prospective owner reports that there are no intended changes to the current quality management system. Any changes that are made will only occur following a thorough investigation of current systems and with the cooperation and input from the existing management team.  Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. There are no plans by the prospective owner to make any immediate changes to Kaikohe Care Centre’s current policies and procedures.  The monthly collating of quality and risk data includes (but is not limited to) residents’ falls, infection rates, and skin tears. There have been no pressure injuries. Data is collated, analysed and evaluated. Results are benchmarked against other care facilities in the far North. Quality results are discussed in the staff/quality meeting minutes.  An internal audit schedule is in place. Not all internal audits have been completed as planned. Corrective actions have been developed where opportunities for improvements were identified. Corrective actions are discussed with staff, evidenced in the meeting minutes.  Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls, sensor mats and the availability of physiotherapy services.  The health and safety programme meets current legislative requirements and it is overseen by a health and safety officer. A health and safety induction programme is in place. Hazard identification forms and a hazard register are in place. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | The service collects a comprehensive set of data relating to adverse, unplanned and untoward events, which is linked to the quality and risk management system. Immediate actions taken are documented on the sample of accident/incident forms reviewed. The forms are reviewed and investigated by an RN. If risks are identified, these are processed as hazards and are reported in the staff/quality meeting. Neurological observations are completed if there is a suspected injury to the head.  Discussions with the facility manager confirmed her awareness of statutory requirements in relation to essential notification. Examples were provided. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Job descriptions are in place for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses and other health professionals were current. Eight staff files were reviewed (five caregivers, one clinical nurse leader/RN and two RNs). Evidence of signed employment contracts, job descriptions, orientation, and staff training were sighted. Annual performance appraisals for staff were up-to-date. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with all three caregivers confirmed that the orientation programme included a period of supervision over three shifts.  The service has a training policy and schedule for in-service education. Caregivers working in the dementia unit who have been employed for over one year have their dementia qualification.  Mandatory fire and emergency management training is conducted annually with the last training completed in 2015.  The facility manager provides one-on-one training for those staff who are unable to attend.  Fire drills are completed six monthly. The in-service records provided reflect low attendance rates.  A system for determining staff competency is implemented for staff around cultural safety and restraint minimisation. Competencies for RNs includes (but is not limited to) medication and syringe driver. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. An RN is scheduled on duty to cover 24 hours a day, seven days a week.  Separate cleaning and laundry staff are available five days a week. Activities staff are available seven days a week.  AM shift  Three RN’s for two days a week (to cover GP rounds) and two RNs the remaining five days a week. Seven caregivers (six for a full shift and one for a short shift 7-11) cover the AM shift with two of the seven caregivers scheduled full shifts (7-3) in the dementia unit.  PM shift  One RN and seven caregivers (four full shifts and three short shifts). Again two of the seven caregivers are scheduled in the dementia unit (one full shift and one short shift (6 hours).  Night  In addition to the RN, there are a minimum of three caregivers  Staff reported that staffing levels and the skill mix was safe. Interviews with residents and families confirmed that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity.  The prospective provider has had time to complete a thorough investigation into current staffing needs and reports feeling confident that the current management team will maintain their efforts to keep the mix and quality of staff the same as what is currently in place. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident’s individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area.  Residents’ files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant caregiver or nurse, including designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements were signed in all resident’s sampled records. Admission agreements reflect all the contractual requirements. Residents reported that the facility manager discussed the admission agreements with them in detail. All residents had the appropriate needs assessments prior to admission to the service. The facility manager, a registered nurse, ensures that residents are admitted to the service as per contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | A standard transfer notification form from the district health board is utilised when residents are required to be transferred to the public hospital or to another service. The facility manager verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the service. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The service uses individualised medication blister packs, which are checked on delivery by a registered nurse. Two registered nurses and medication competent caregivers were observed administering medications correctly in each area. The facility utilises medication charts and signing sheets to record prescribing and administration of medications however, not all medication charts reviewed evidenced fully completed documentation. Resident photos were attached to all medication charts reviewed. Known allergies or no allergies were not consistently documented. Medications are reviewed three monthly with medical reviews by the attending GP.  An annual medication administration competency was completed for all staff administrating medications and medication training had been conducted. Current medication competencies were evidenced in the staff files. All medications were stored appropriately.  Two residents self-administered medications. The self-administration policies and procedures were in place and both residents had a secure drawer for storage of medication in their bedroom. ‘As required’ medication (PRN) was reviewed by a registered nurse each time prior to administration. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. All meals are prepared and cooked on-site by the kitchen staff. All staff have had food safety training. The current menu has been approved by a dietitian.  Residents are provided with meals that meet their food, fluids and nutritional needs. The registered nurse completes the dietary requirement forms on admission and provides a copy to the kitchen. Additional or modified foods are also provided by the service. Nutritional snacks and additional food is available for the dementia unit residents at any time.  Fridge and food temperatures were monitored and recorded weekly. Cooked meals are transferred into heated bain-maries and transported from the kitchen, directly to the dining rooms. The meals were well presented and residents confirmed that they are provided with alternative meals as per request. All residents are weighed monthly. Residents with weight loss problems are provided with food supplements. Residents interviewed spoke positively about the food provided. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | There is a documented policy on decline of entry to the service. Advised by the facility manager that anyone declined entry is referred back to the referring agency for appropriate placement and advice. The district health board needs assessors and social workers contact the manager to discuss the suitability of the potential resident, prior to sending the potential resident and their family to view the facility. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The registered nurses utilise standardised risk assessment tools on admission and the InterRAI assessment tool. InterRAI assessments, assessment notes and summaries were in place for all residents’ files reviewed. The long-term care plans in place reflected the outcome of the assessments. Cultural, sexuality and intimacy needs have been identified for the residents. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The long-term care plans sampled were resident-focused. The care plans described the resident’s goals, supports and interventions required to meet desired goals as identified during the assessment process. There is documented evidence of resident and/or family input ensuring a resident-focused approach to care. Residents confirmed on interview that they are involved in the care planning and review process. There was evidence of allied health care professionals involved in the care of the resident. Long-term care plans sampled have been reviewed and updated in a timely manner, following a decline in health. Short-term care plans had been developed following a change in health. Not all documented interventions were sufficiently detailed to address the desired outcome/goal in the long-term care plans. Diversional therapy plans reviewed did not consistently document the interventions required to achieve the residents’ goals. There is documented evidence of resident and/or family input ensuring integration of records, and monitoring documents are well-managed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Residents interviewed confirmed care delivery and support by staff is consistent with their expectations. The residents interviewed expressed satisfaction with the clinical care and that they are involved in the care planning. Caregivers interviewed stated there is adequate equipment provided including continence and wound care supplies. On the day of the audit, supplies of these products were sighted.  The service maintains close links with mental health services. Behavioural issues were observed to be well managed however, interventions were not documented in the care plans to reflect the distraction/de-escalation techniques required to manage behaviours (link to 1.3.5.2).  There were no pressure injuries being treated at the time of the audit. Wounds currently being treated included, three skin tears and one blister. The two registered nurses and clinical lead interviewed could describe the referral process to a wound specialist or continence nurse. Monitoring occurs for weight, vital signs, blood glucose and challenging behaviour. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs two diversional therapists across seven days a week. Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The two diversional therapists interviewed displayed an understanding of requirements. Caregivers support all activities.  The weekly activities are posted on a large whiteboard in the main hallway and on residents noticeboards in each area and include outings, baking, table tennis, bowls, bingo, church services and quizzes. The diversional therapy plans sampled reflected the residents preferred activities and interests. Each resident has an individual activities assessment on admission. The diversional therapy plan is reviewed six monthly at the multidisciplinary meetings. The reviews document the resident’s progress towards meeting goals however; five of seven diversional therapy plans reviewed did not document interventions towards achieving the residents’ desired goals (link to finding 1.3.5.2). The resident’s activities participation log was sighted. Residents interviewed indicated the activities provided by the service are adequate and enjoyable. On the days of audit, some residents were observed being actively involved in group games, while others were going out on a trip. Residents interviewed spoke positively about activities available. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurse evaluates all initial care plans within three weeks of admission. Long-term care plan evaluations sighted have been reviewed regularly and document progress towards goals. Short-term care plans reviewed had been utilised for all short-term care issues. Care staff document progress notes on every shift. Registered nurse entries in progress notes were evident. The GP completes a three monthly resident review or earlier if required. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and the families are kept informed of the referrals made by the service. The registered nurse facilitates internal referrals. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | All chemicals were securely stored. Storage areas both inside and outside were locked. Chemicals were clearly labelled and safety material datasheets were available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they could access personal protective clothing and equipment at any time. As observed during the audit, staff were wearing gloves, aprons and hats when required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. The facility has a current building warrant of fitness.  A new call bell system was installed in 2015. Both internal maintenance and external contractors undertake maintenance. Electrical safety test-tag system shows this has occurred. Some areas requiring maintenance were observed during the audit. One resident room in the protected living environment (dementia unit) had a large area of ripped and torn wallpaper, peeling ceiling paint was observed in the hallway of the dementia unit. The facility manager advised that the decorator had been advised of the maintenance required and that arrangements had been made for these to be completed. The maintenance to be carried out also included the painting of the roof when weather permitted. Documentation was sighted which supported that maintenance was to be completed. All maintenance records were reviewed and are clearly documented. Review of the records reveals water temperatures are all below 45 degrees Celsius and whenever it was out of range, corrective actions had been taken.  All external areas inspected are safe and include appropriate seating and shade. The dementia unit has a safe, fully fenced outdoor area, with seating areas provided for shade. A new gate with keypad access has recently been installed in the dementia unit garden. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | One rest home and one hospital room have an ensuite and all others shared communal toilets and showers. There were sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities were available. Residents interviewed stated their privacy and dignity were maintained while attending to their personal cares and hygiene. The communal toilets and showers are well signed and identifiable and include vacant/in-use signs. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | The resident rooms were spacious enough to meet the assessed resident’s needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms are personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are large lounges, activity rooms and dining rooms in the rest home and hospital areas. The lounge and dining areas in the dementia unit are homely and easily accessible to all residents. Residents in all areas have access to smaller quiet lounges. All areas are easily accessible for the residents.  The furnishings and seating are appropriate for the consumer groups. Residents interviewed reported they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges. During the audit, residents were observed sitting in the covered decking areas, reading or engaging in craft activities. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Domestic staff are responsible for cleaning and laundry service. There are sufficient staff allocated seven days a week to carry out these services. The service conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective (link to finding 1.2.3.6). Where improvements can be made these are implemented. Current safety material datasheets about each product are located with the chemicals. The chemicals are stored appropriately in locked cabinets at all times. Cleaners’ trolleys are stored in a locked room when not in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and annual education and training programme include fire and security training (link to finding 1.2.7.5). Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.  A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A power generator and gas barbeque are available.  A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity.  There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal areas and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Kaikohe Care Centre has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the designated infection control person with support from all staff. Infection control matters are routinely discussed at staff meetings. Education has been provided for staff. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme. The infection control (IC) person has maintained practice by attending registered nursing updates via external education. The infection control team is all staff through the staff meeting. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two yearly. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The staff orientation programme includes infection control education. The infection control nurse has completed infection control updates. The infection control nurse provides staff in-service education, which occurred in February 2016 (link to finding 1.2.7.5). Education is provided to residents in the course of daily support with all residents interviewed able to describe infection prevention practice that is safe and suitable for the setting. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator and an enrolled nurse collate information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections in place are appropriate to the complexity of service provided. Infection control data is discussed at both the registered nurse and general staff meetings. Annual infection control reports are provided. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule and have been completed as per the schedule. The infection rate is low and there have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. Four residents (hospital level) were using restraints and two residents (hospital level) were using enablers.  One file of a resident using bedrails as an enabler was reviewed. Documentation met all requirements of the restraint standard for enabler use.  Staff receive mandatory training around restraint minimisation (link to finding 1.2.7.5). In addition to in-service training, staff are requested to complete competency questionnaires (sighted for 2016). These questionnaires ask staff to differentiate a restraint from an enabler. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | A restraint approval process and a job description for the restraint coordinator are in place. Restraint minimisation policies and procedures describe approved restraints. The clinical nurse leader/RN is the designated resident coordinator. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Low | The restraint coordinator is responsible for assessing a resident’s need for restraint. Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family, and observations by staff. A restraint/enabler assessment tool is being implemented.  Two hospital level residents’ files where restraint was being used were selected for review. Each file included a restraint assessment but risks were not identified on the assessment. Restraint use was linked to the resident’s care plan in one of two residents’ files reviewed. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A restraint register is in place. The register identifies the residents that are using a restraint, and the type of restraint used. Four hospital level residents were using restraints (safety vests and/or bedrails). The restraint assessments reviewed identified that restraint is being used only as a last resort.  The frequency of monitoring residents while on restraint is documented. Residents using restraints and enablers were being monitored every two hours. Monitoring forms are completed when the restraint is put on and when it is taken off. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint use is reviewed three-monthly by the restraint coordinator, meeting requirements of the standard. Restraint use is discussed in the RN meetings and staff/quality meetings. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint programme, including reviewing policies and procedures and staff education is evaluated as evidenced in the document control for restraint policies and procedures, in the staff/quality meetings and in discussions with the facility manager and restraint coordinator. |

# 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)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality data is being collected, analysed and evaluated with results communicated to staff. Results are also benchmarked against other aged care facilities in the far North. An internal audit schedule for 2016 is established but audits are not always completed as per the audit schedule. | The 2016 audit schedule is not being completed as planned, with eight audits not completed in 2016 (year-to-date). The facility manager reported that she delegates internal audits to staff but that these have not always been completed and returned. | Ensure internal audits are completed as per the internal audit schedule.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | An education and training programme is being implemented. ACE training is provided for caregivers. Nine caregivers work in the dementia unit and five have completed their dementia national qualification. The remaining four caregivers have been employed for less than one year.  Attendance at in-services is low. The facility manager did repeat one in-service twice (abuse and neglect) and reported that this improved attendance rates. The caregivers interviewed confirmed that staff do not want to come back to the facility to attend training if they are not scheduled to work. | Fifty-eight staff are employed by the service with 44 care staff (36 caregivers and activities staff, and eight RNs). The 2016 in-service education and training provided for staff reflected low attendance rates (eg, code of rights (13 attended), abuse neglect (8), challenging behaviours (8), infection control (13), skin care (11), diabetes (8), restraint minimisation (3), chemical handling (2)). | Ensure staff attend all mandatory education and training and can demonstrate that they have each attended 8 hours annually as per the aged related care (ARC) contract.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | A medication management system is in place. Staff medication competencies are completed annually and were evidenced in staff files reviewed. The GP reviews the medication chart when completing three monthly medical reviews. Eleven medication charts reviewed evidenced that medications had been administered as prescribed. Twelve medication charts included the commencement date of the prescribed medication. | i) Three of fourteen medication chart signing sheets reviewed (a sample from each area) did not evidence that medications had been administered as prescribed; and ii) Two of fourteen medication charts did not document the commencement date of the prescribed medication. | i) Ensure that medications are administered as prescribed; and ii) ensure that all medication orders include a commencement date.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The care plans and diversional therapy plans describe the residents’ goals. Interventions were consistently documented in two dementia resident diversional therapy plans reviewed. Two of four behaviour management care plans (one dementia and one rest home) were fully documented and described the interventions and supports required to meet the resident’s assessed needs. | i) Two rest home and three hospital resident (including one hospital YPD) diversional therapy plans, did not document the interventions required to assist the residents to achieve their desired goals; ii) one rest home resident care plan did not document the management of diagnosis of diabetes; and iii) two of four behavioural management plans (one dementia and one hospital) reviewed did not document resident specific de-escalation or distraction techniques that could be used to prevent or manage behavioural issues. | i) Ensure that diversional therapy plans document the interventions required to achieve goals; ii) ensure that nursing management of medical conditions are documented in care plans; and iii) ensure that behavioural management plans document resident specific de-escalation or distraction techniques.  60 days |
| Criterion 2.2.2.1  In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies. | PA Low | The restraint assessment process identifies the residents’ needs for restraint. The identification of associated risks was not completed in the two files selected for review where restraint was in use. Restraint use was missing in one of two care plans (link 1.3.5.2). | i) Risks associated with restraint use were not being recorded on the restraint assessment in two of two residents’ files reviewed; and ii) Restraint use was not documented in one of two care plans where restraints were being used. | i) Ensure risks associated with the use of restraint are identified as part of the restraint assessment process; and ii) Ensure residents using restraint have restraint use identified in their care plans.  90 days |

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

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

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

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

|  |
| --- |
| No data to display |

End of the report.