# Kaylex Care (Fielding) Limited

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Kaylex Care (Fielding) Limited

**Premises audited:** Woodfall Lodge Retirement Home

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

**Dates of audit:** Start date: 3 November 2015 End date: 3 November 2015

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 33

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | 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 |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Woodfall Lodge Retirement Home provides rest home and hospital level care for up to 36 residents. The service is managed by a facility manager and a clinical care manager. The residents and families reported they are provided with adequate care.

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

The areas that required improvement from the last audit relating to call bell responses and ensuring privacy of residents have been addressed.

There are 17 areas identified as requiring improvement from this audit relating to effective communication with residents and families, complaint management, reporting to the governing body, audit schedule and completed audits, the document control system, analysing quality data, corrective actions, staff recruitment, orientation, performance appraisals, staff education, practising certificates, resident documentation, medicine management, aspects of the food service and aspects of the physical environment.

## Consumer rights

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Staff demonstrated an understanding of residents' rights and obligations. Information regarding residents’ rights, access to interpreter services and how to lodge a complaint was available to residents and their families. The complaints register is current and all complaints have been entered. Documentation does not include whether the complainants were satisfied with the outcome of the complaint and complaints relating to staff are not included in the staff files.

There has been one investigation completed by the Health and Disability Commissioner’s advocate since the last certification audit.

Care provided to residents is in accordance with consumer rights legislation. Residents’ values, beliefs, dignity and privacy are respected. A previous corrective action concerning residents’ privacy has been addressed. At times the environment is not conducive to effective communication and this requires some attention.

## 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. |

Kaylex Care (Fielding) Limited is the governing body and is responsible for the services provided at this facility. A business plan and a quality and risk management plan were reviewed. The manager participates in meetings held every two weeks with the owners via ‘Skype’. However, the monthly managers’ report is completed by the manager of another facility within the group and copies of the reports were not available.

The facility is managed by a facility manager who is a registered nurse and has been in this role since July 2015. The facility manager is supported by a clinical care manager who is responsible for the oversight of the clinical services in the facility.

Clinical indicators are reported to the owners by the facility manager for benchmarking; however results are not reported back to the facility. There is an internal audit programme, but this has not been followed. Risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, infection control surveillance, accident/incident forms, meeting minutes and surveys shows a lack of analysis of data and corrective action plans are not being developed to address any issue/s that required improvement.

Reporting on the numbers of various clinical indicators, quality and risk issues are reported via the quality and staff meetings. Graphs of clinical indicators are available for staff to view along with meeting minutes.

Although there are up to date documents, including policies and procedures held electronically, the documentation in use is not current.

There are policies and procedures on human resource management. Not all staff files evidenced job descriptions, orientation, performance appraisals, and police vetting. Not all GP practising certificates held on file are current.

An in-service education programme is provided for staff monthly. Caregivers are also required to complete the New Zealand Qualifications Authority Unit Standards. The infection control coordinator has no formal infection control training, not all clinical staff have current restraint competency assessments, and the cooks do not have current food safety certificates.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The facility manager is rostered on call after hours. Care staff interviewed reported there is adequate staff available.

## 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. |

All residents’ files sighted provided evidence that needs, goals and outcomes are identified; however documentation in some files shows inconsistencies in aspects of the service with regards to residents’ present and changing needs. Corrective action is required around this as well as the frequency of GP visits. Residents reported they were well looked after, however at times some residents/family/whanau did not feel well informed of changes.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted are not always consistent with these documents.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines; however no evidence was sighted of attention to recommendations made. Improvements are required around some aspects of food storage and preparation. Residents have a role in menu choice, though interviews with residents verified some dissatisfaction with meals.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

A current building warrant of fitness is displayed. Free standing oil heaters were situated in passageways and in residents’ rooms with long electrical cords running across the floors. The tap over the sink in the kitchen is not able to be turned off and hot water is running freely into the sink. These are areas for improvement.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Documentation of policies and procedures and interview of the facility manager demonstrated residents are experiencing services that are the least restrictive. There are currently no residents using restraint or enablers.

## Infection prevention and control

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

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated; however no analysis of the findings is sighted. Surveillance results are benchmarked with the provider’s other facilities.

## 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 | 7 | 0 | 5 | 6 | 0 | 0 |
| **Criteria** | 0 | 26 | 0 | 9 | 8 | 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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The facility manager is responsible for the management of complaints. There are appropriate systems in place to manage the complaints processes. The complaints register is current and evidenced 14 written and verbal complaints received for 2015. Documentation showed all complaints have been investigated and complainants provided with responses in a timely manner. There was no evidence of whether the complainants were satisfied with the outcome of the complaint. Staff files do not include documentation relating to complaints about staff.  There has been one investigation by a Health and Disability Services advocate this year concerning the care of a resident. This has been addressed and is now closed. There have been no investigations by the Ministry of Health, DHB, Health and Disability Commissioner, Accident Compensation Corporation (ACC), Coroner or Police since the previous certification audit.  Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). Systems are in place that ensures residents and their families are advised on entry to the facility of the complaint processes. Residents and families demonstrated an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues during these meetings. Residents and families interviewed and review of resident meeting minutes confirmed this. Review of the collated resident and family surveys for 2015 evidenced residents and families knew the process for making a complaint.  The complaint process and forms were observed to be readily accessible and displayed. Quality and staff meeting minutes evidenced reporting of any complaints is an agenda item. Care staff confirmed information was reported to them via their staff meetings. |
| 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 | Residents’ are treated with respect and staff have regard for their dignity, privacy, sexuality, spirituality and independence.  Staff demonstrated policy awareness and responsiveness to residents’ needs. A previous corrective action concerning residents’ privacy has been addressed as verified by interviews, observation and documentation |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Moderate | The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided and communication with relatives is documented in the residents’ communication records and incident forms. Access to interpreter services is available when necessary.  Observation, interviews and documentation shows that the environment is not always conducive to effective communication. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | A current business plan for the facility includes goals and objectives, a mission statement, values, a vision and objectives. There are systems in place for monitoring the service, however regular electronic monthly reporting is completed by the manager of another facility within the group, to the governing body. Benchmarking with the other facilities in the Kaylex Care group is also completed; however the results are not reported back to the facility manager at Woodfall Lodge. The facility manager confirmed this.  The facility is managed by a facility manager who is a registered nurse and has been in this role since July 2015. The facility manager prior to this appointment was the clinical care manager and has also held facility manager positions in other facilities. The facility manager is supported by a clinical care manager. Prior to this appointment they were a RN at this facility. The clinical care manager also has prior experience as a clinical manager. The facility manager is also supported by another facility manager within the organisation and the facility manager advised this manager visits on a weekly basis. The annual practising certificates for the facility manager and clinical care manager were reviewed and are current. There was evidence in the facility manager’s and clinical care manager’s files of ongoing education.  The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.  Woodfall Lodge is certified to provide hospital level, and rest home level care. All beds have been approved to use as dual purpose beds. On the day of this audit there were 13 hospital level care residents and 20 rest home level care residents. |
| 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 Moderate | A quality and risk management plan is used to guide the quality programme and includes goals and objectives.  The resident and family satisfaction surveys have been collated for 2015 and results indicated that residents and families were satisfied with the services provided apart from communication (refer to criterion 1.1.9.1).  Clinical indicators and quality improvement data was recorded on various registers and forms both hard copy and electronically. Quality improvement data is being collected and collated. Comprehensively analysed of data to identify trends was inconsistent and corrective actions are not developed when required.  The facility manager provides clinical indicators to the owners monthly for benchmarking. There was no benchmarking data available and the facility manager reported results are not reported back to Woodfall Lodge. Quality, staff and residents’ meetings are held monthly and minutes were reviewed. The facility manager and staff stated quality data is discussed at the various meetings. There was evidence in minutes of meetings of reporting of the numbers of clinical indicators and quality and risk issues. Care staff reported that copies of meeting minutes and graphs are available for them to review in the staff areas. Observations confirmed this.  Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and references legislative requirements. Policies and procedures are reviewed by the owners and are current and provided electronically via ‘drop box’. However, policies and procedures, and other documentation used in the facility were not current, with review dates ranging from 2011 to mid-2014.  A health and safety manual is available. There is a hazard reporting system available as well as a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual and clinical risks. |
| 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 | Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the facility manager and signed off when completed. Corrective action plans to address areas requiring improvement are documented on accident/incident forms. The registered nurses undertake assessments of residents following an accident. The registered nurses complete neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.  Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they complete accident/incident forms for adverse events. Policy and procedures comply with essential notification reporting, for example health and safety, human resources, infection control. The facility manager reported they have not had any events to report concerning essential notifications. |
| 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 Moderate | The facility manager is responsible for the in-service education programme at Woodfall Lodge and advised that in-service education sessions are provided at least once a month. The 2015 training programme confirmed this. Care staff reported they have attended training sessions monthly and this was confirmed in individual attendance records reviewed. Caregivers are also required to complete relevant New Zealand Qualifications Authority Unit Standards. There are two internal assessors at Woodfall Lodge to support this.  The infection control coordinator has not received any formal education relating to infection control. All staff responsible for medicine management have current competencies. Not all clinical staff have current restraint competency assessments. One of the two cooks last completed training in food safety in 2010 and there was no evidence on the other cook’s file to indicate they had completed any training relating to food safety.  The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority. All files had reference checking and employment agreements; however, the section on confidentiality only references the employer and does not include confidentiality of resident information and documentation. Not all files have a job description including the facility manager and not all files had evidence of police checking.  There are policies and procedures on human resources management and annual practising certificates for registered nurses and pharmacists are current. Not all GP practising certificates reviewed were current. An appraisal schedule is in place and current appraisals were sighted on five of the seven staff files. Staff at interview confirmed they have a current appraisal.  The facility manager described the orientation programme provided at Woodfall Lodge that covers the essential components of the service provided. Not all files have evidence of an orientation, including the facility manager, who confirmed they have not received an orientation to the position of facility manager. Staff confirmed they had received an orientation and attend education sessions. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse cover is provided 24 hours, seven days a week. On call after hours is provided by the facility manager. The minimum number of staff on duty is during the night and consists of a registered nurse (RN) and two caregivers.  Staff interviewed reported there is adequate staff available and that they are able to get through their work. All care staff have a current first aid certificate. Residents interviewed reported staff provide them with adequate care. Observations during this audit confirmed adequate staff cover is provided. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | A safe system for medicine management using a new electronic medication management system was observed on the day of audit.  The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Controlled drugs are stored in separate locked cupboards. Controlled drugs are checked by two nurses for accuracy in administration, however this is not always verified. The controlled drug register evidences weekly and six monthly stock checks and accurate records.  The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.   The three monthly GP review of all residents’ medication has not been verified on the residents’ electronic medication record, they have been informed however have not attended to the matter.  Residents’ who wish to self-administer may do so, with agreement to comply with the appropriate processes in place to ensure this is managed in a safe manner.  Evidence of reconciliation and checks for expired medications were sighted.  Medication errors are reported to the clinical care manager and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for the analysis of any medication errors, and compliance with this process is verified.   Standing orders are used in relation to each resident’s individual circumstances. Documentation is compliant with standing orders guidelines. |
| 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. | PA Moderate | The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian’s documented assessment of the planned menu in 2011. The menu remains the same, however there is no evidence that the recommendations from that review and for a subsequent review in 2013 have been attended to (refer1.2.3.8).  A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan, however the cook was unaware of changes in some residents’ dietary requirements (refer 1.3.6.1). Special equipment to meet resident’s nutritional needs was sighted.  Some aspects of food preparation and storage is noncompliant with current legislation and guidelines. A cleaning schedule is sighted however there is no verification of compliance with this.  Evidence of resident satisfaction with meals is varied, as verified by resident and family/whanau interviews, sighted satisfaction surveys, audits and resident meeting minutes (refer 1.2.3.8).  There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Documentation, observation and interviews verified residents received appropriate services to meet their assessed needs; however some files reviewed identified some areas of inconsistency.  Residents and all but one family/whanau member expressed satisfaction with the care provided.  There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents’ needs. |
| 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 | Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents (refer 1.3.8.2). The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.  A residents’ meeting is held monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | Resident care is evaluated daily and reported in the progress notes. If any change is noted it is reported to the RN.  Formal care plan evaluations, following reassessment to measure the degree of a resident’s response in relation to desired outcomes and goals occur every six months or as residents’ needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan. A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process; however the above process is not occurring consistently.  Interviews and documentation verified residents and family/whanau are at time not informed of all changes (refer 1.1.9.1) |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | A current building warrant of fitness is displayed that expires on the 25 June 2016.  Free standing oil filled heaters were observed in passageways and in resident’s rooms during the audit. The facility manager reported extra heating was required because the facility was not warm enough on cold days. At interview the maintenance person reported the underfloor heating was not working as it should be. The oil heaters in the passage ways were removed while the auditors were on site. However, the heaters in the resident’s rooms remained in place.  The tap over the sink in the kitchen was leaking and hot water was running into the sink even though the tap was turned off. The maintenance person reported they have completed maintenance on the tap a number of times and that the tap is now beyond repair. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner. The resident survey for 2015 and resident meeting minutes confirmed this. The requirement from the last certification audit has been addressed. |
| 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 | In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. These are collated each month; however no evidence of analysis to identify any significant trends or possible causative factors was sighted (refer criterion 1.2.3.6)  Incidents of infections are presented at the quality meetings and any ongoing corrective actions discussed and presented to staff at staff meetings, as evidenced by meeting records, infection control records and staff interviews. Any immediate action required is presented to staff at hand over. Incidents of infections are benchmarked with the organisations other facilities (refer criterion 1.2.3.6). |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enablers is congruent with the relevant standard. There are no residents using restraint or enablers and the facility manager advised restraint has not been used for a number of years. Staff were able to describe the process should restraint be required.  Not all clinical staff have competency assessments relating to restraint minimisation and safe practice (Refer to criterion 1.2.7.5). |

# 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 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | A sample of complaint documentation reviewed showed timeframes were met for responding to complaints made. The complaints register is current and includes all complaints for 2015. Complaint forms are accessible for residents and families and complaint processes are part of the admission process for residents. Residents, families and staff demonstrated an awareness of complaint processes. Apart from the documentation from the Health and Disability Services advocate, there was no evidence of whether the complainants were satisfied with the outcome of the complaint they had made. Where there had been a complaint concerning a staff member, there was no evidence of the complaint held on individual files. | There was no evidence documented to indicate complainants were satisfied with the outcome of the complaint. Staff files do not include documentation concerning complaints made about a staff member. | The complaints process includes evidence to indicate that the complainant is satisfied with the outcome of the complaint. Include documentation on staff files as a result of complaints made about staff members.  180 days |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Moderate | Staff were observed to not always wear name badges, despite a request by residents for them to do so, as recorded in the residents’ meeting minutes. Interviews with residents’ and families identified that they were not always kept up to date with changes in care needs and this was also noted to be a frequent concern mentioned in the recent resident and family satisfaction survey. | The environment is one that is not always conducive to effective communication. | Provide evidence the environment is conducive to effective communication.  90 days |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | The business plan includes a mission statement, purpose, goals, and direction of the organisation. The facility manager participates in two weekly meetings held with the owners via ‘skype’. Minutes reviewed showed items discussed include occupation levels, training and general business. The facility manager reported they do not write the monthly report for Woodfall Lodge. This is done by the facility manager of another facility within the group, and sent to the owners. There were no reports to review and the facility manager advised they are not sent them. | The facility manager does not write the monthly report for Woodfall Lodge that is sent to the owners, and there were no copies of the report for review. | Review the practise of the facility manager for Woodfall Lodge not completing reports to the owners nor receiving a copy.  180 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 | A quality and risk management plan is used to guide the quality programme and includes goals and objectives. The facility manager and staff demonstrated knowledge of the quality and risk management system. Staff reported they discuss quality data at both the quality and staff meetings. There is an audit programme dated 2013 (refer to criterion 1.2.3.4), however, only three audits have been completed for 2015 (kitchen, cleaning and the environment). The programme does not include audits for medicine management apart from the pharmacist completing a six monthly controlled drug audit. | Audits are not being completed as defined in the audit programme and there is no audit for the management of medication. | Complete audits as per the audit programme and expand the programme to include audits for medicine management.  90 days |
| Criterion 1.2.3.4  There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. | PA Low | There is a document control system to manage documentation. Up to date policies and procedures, forms and tools are available electronically for download from the ‘drop box’. Documentation in use at Woodfall Lodge is not current and has review dates ranging from 2011 to mid-2014. | Documents used at Woodfall Lodge are not up to date. | Provide evidence that all documents are up to date and made available to staff.  180 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 Moderate | Quality improvement data is being collected and collated, but it is not being comprehensively analysed to identify trends. A number of clinical indicators are reported in the meeting minutes and staff reported they do discuss these. Quality data is sent to the owners by the facility manager for benchmarking. The facility manager reported they do not receive any feedback from this and do not know how Woodfall Lodge stands within the benchmarking group. | Quality data is not consistently being comprehensively analysed to identify trends and there is no reporting back to the facility manager of results following benchmarking. | Quality data is comprehensively analysed to identify trends, and results of benchmarking reported back to the facility manager.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Incident/accident forms have evidence of corrective actions. Other documentation including audits, surveys, meeting minutes, and the menu review do not have corrective actions developed and implemented. | Apart from incident/accident forms, corrective actions are not being developed and implemented to address areas requiring improvement. | Develop and implement corrective action plans for all identified deficits.  90 days |
| Criterion 1.2.7.2  Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Low | Current practising certificates are on file for registered nurses and the pharmacists. Two of the nine GPs who visit Woodfall Lodge have practising certificates on file that are not current. | Two of the nine GPs do not have a copy of their current practising certificate on file. | Provide evidence that all health professionals who provide services to Woodfall Lodge have current practising certificates.  180 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | All staff files reviewed had competed application forms and reference checks. Although all files reviewed had signed employment agreements, the section on confidentiality references the employer and does not include the confidentiality of resident information and documentation. Three of the seven files do not have a job description including the facility manager. Five of the seven files have no evidence of police checking. | Not all recruitment and human resources requirements were evidenced in the staff files reviewed. | Provide evidence that recruitment and human resources requirements are completed for all staff.  180 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | The orientation programme provided covers the essential components of the service provided. Orientation is completed over three months. Care staff stated they had received an orientation. Four of the seven files did not have evidence of an orientation, including the facility manager, who confirmed they have not received an orientation to the position of facility manager. | Four of the seven staff files reviewed had no evidence of an orientation completed. | Provide evidence that all staff receive an orientation.  180 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 Moderate | A training programme for 2015 was reviewed and ongoing education is provided at least monthly. Review of attendance records and staff interviews confirmed this. All staff responsible for medicine management have current competencies. Not all clinical staff have current restraint competency assessments. One of the two cooks last completed training in food safety in 2010 and there was no evidence on the other cook’s file to indicate they had completed any training relating to food safety. The infection control coordinator has not received any formal education relating to infection control. | Nine of the 30 clinical staff do not have a current competency assessments for restraint. The infection control coordinator has not received formal training relating to infection prevention and control. One cook does not have current training relating to food safety and there is no evidence available that the other cook has completed any training relating to food safety. | Provide evidence that: (i) all clinical staff have current restraint competencies; (ii) the infection control coordinator has attended infection prevention and control training; (iii) both cooks have a current certificate in food safety.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | An electronic medicine management system has been implemented to manage the safe and appropriate management of medicines. Controlled drugs are checked by two nurses for accuracy in administration, however intermittently the controlled drug register has only been signed by one person not two. No discrepancy in stock numbers was evident.  Despite evidence being sighted, reminding some GPs their residents require a three monthly medication review, not all electronic medication charts reviewed verify this has occurred. | Aspects of medicine management is not compliant with contractual requirements, legislation, protocols and guidelines. | Medicine management complies with contractual requirements, legislation, protocols and guidelines.  180 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Moderate | Some aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines, however not all. There is no verification of compliance with the cleaning schedule in the kitchen, however an audit of the cleaning in the kitchen has been completed. There is no record that the temperature of the meat has been checked when it is cooked to ensure it is cooked properly.  Shelves in the chiller are bare wood with evidence of liquid spillage soaked into the wood.  The floor of the chiller is chipped and rusty in parts.  Not all food in the fridge is dated. | Some aspects of food preparation and storage is noncompliant with current legislation and guidelines. | Provide evidence all aspects of food preparation and storage is compliant with current legislation and guidelines.  90 days |
| 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. | PA Low | Each resident had interRAI assessment and reassessments completed and associated risk factors identified where required, however files reviewed did not consistently have documentation to identify the GP has assessed that the resident is stable and suitable for three monthly medical reviews rather than the required monthly review. | Some aspects of service are not completed within the required timeframes. | The provision of services is within the required time frames.  180 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Interviews verified residents’ received appropriate services to meet their needs, however three of the files reviewed did not evidence consistency. A resident with weight loss and a change in meal requirement, has no documented interventions detailing this requirement, nor is the food service aware of the change in resident’s dietary need. A resident identified as at risk for developing pressure areas has no documentation of the actions required to minimise the risk. A resident suffering from an alteration in mood level has no interventions to manage this aspect of the resident’s need. | Interventions are not always consistent with the resident’s assessed needs. | Interventions describe the actions required to meet the resident’s assessed needs.  90 days |
| Criterion 1.3.8.2  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. | PA Low | Evaluations in regards to residents’ activities needs were occurring however not within the six month time frame. Short term care plans were in place and described the required support, however no evaluation has been undertaken to determine if the desired outcome had been achieved. | Care plans are not evaluated in a comprehensive and timely manner. | Care plans are evaluated within required timeframes.  180 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | Free standing oil filled heaters were observed in passageways and in resident’s rooms. These heaters were hot to touch, were not secured and had long electrical cords running along floors to power sockets. The facility manager reported the heaters were in place because the facility was not warm enough on cold days even though the facility is heated with underfloor heating. At interview the maintenance person reported the underfloor heating was not working as it should be and that during the summer months it is to be serviced. The oil heaters in the passage ways were removed while the auditors were on site. However, the heaters in the resident’s rooms were not removed and in one resident’s room the electrical cord ran from the heater out the bedroom door and into a power socket in the passageway.  The tap over the sink in the kitchen was leaking and hot water was running into the sink even though the tap was turned off. The maintenance person reported they have completed maintenance on the tap a number of times; however the tap is now beyond repair. | Free standing oil heaters which are unsafe are being used to heat the facility as the under floor heating system does not provide sufficient heat on cold days. The tap over the sink in the kitchen is leaking with hot water running into the sink and is a potential risk to residents. The tap has been repaired on a number of occasions and is now beyond repair. | Provide evidence that: (i) the facility is heated safely and residents are not exposed to risk from portable heaters that are hot to the touch and have long electrical cords; (ii) the tap in the kitchen is replaced.  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.

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End of the report.