

Kaylex Care (Fielding) Limited - Woodfall Lodge Retirement Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Kaylex Care (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: 14 December 2016 End date: 15 December 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:	32

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

Indicator	Description	Definition
	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 is one of three aged residential care facilities owned by Kaylex Care Limited. Woodfall Lodge Retirement Home has 38 beds and provides both hospital and rest home level care. At the time of audit there are 22 rest home level care and 10 hospital level care residents receiving care.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, families/whānau, management and staff.

A new facility manager started working in this facility in August 2016 in a temporary capacity while a long term manager was recruited. An external consultant provides support as required. A new operations manager role has been developed.

Family and residents interviewed expressed satisfaction with the care and services provided.

There are six areas identified for improvement related to linking outcomes with quality indicators, document control processes, maintaining recruitment and orientation records, catering staff food safety training, and managing the environment.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated good knowledge and practice around respecting residents' rights, in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

There are four residents and nine staff who identify as Maori. There are no known barriers to Maori residents accessing the service. Services are planned to respect individual culture, values and beliefs of all residents. An interpreter and cultural advisors are available if required.

Informed consent is obtained appropriately and signed consent forms are in residents' records reviewed.

The organisation provides services that reflect current accepted good practice as seen in policy and procedures for service delivery. Education for staff is encouraged and an annual education plan is available.

Linkages with family and the community are encouraged and maintained.

The organisation respects and supports the right of the resident to make a complaint. The service has a complaint register and complaints are managed and documented to meet all the requirements of the standard.

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 low risk.
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The organisation's philosophy, mission and vision statements are identified in the business and strategic plan. The directors ensure service planning covers business strategies for all aspects of service so the services offered meet residents' needs, legislation and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit process, complaints management, incident/accident reporting, family and staff satisfaction surveys, and restraint and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and family/whānau, as appropriate. Corrective action planning is well documented. The facility manager reports regularly to the directors via monthly reports, fortnightly management 'Skype' meetings, or more frequently via email or phone if appropriate.

Clinical and care staff participate in relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Residents and family/whānau confirmed during interview that all their needs and wants are met.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met.

All required resident information is collected in an integrated record and stored in a safe place. The contents are individualised and meet current accepted practice for content and timeliness.

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 low risk.
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Preadmission information clearly and accurately reflects the services offered. The service agreements are signed and dated.

Residents have an initial nursing assessment followed by an interRAI assessment three weeks after admission to the service. The care plan is developed and implemented. Short term care plans are implemented to reflect any changes in needs. InterRAI evaluations are conducted six monthly on all aspects of the care plan.

Residents are reviewed by a GP as clinically indicated and as required by contractual obligations.

The service has planned activities programme to meet the recreational needs of the residents. This area of service is led by a diversional therapist.

A safe medicine administration system was observed at the time of audit. Staff responsible for medicine management are assessed as competent to do so.

Residents` nutritional requirements are met by the services with likes, dislikes and special diets catered for and food available 24 hours a day. The service has a four week, summer/winter rotating menu which is approved by a registered dietitian.

Safe and appropriate environment

<p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substance.

There are documented emergency management response and security processes which are understood and implemented by staff.

The building has a current building warrant of fitness and an approved fire evacuation plan. There have been no changes to the facility footprint since the previous audit.

Furniture and equipment is maintained. All bedrooms are single occupancy. There is adequate toilet, bathing and hand washing facilities. Lounge and dining areas meet residents' relaxation, activity and dining needs.

The facility has central heating throughout. Opening doors and windows create an air flow to keep the facility ventilated and cool when required. The outdoor areas provide furnishings and shade for residents' use. Residents can smoke in designated outside areas only. Residents and family/whānau were happy with the environment provided.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. At the time of the audit, the service has no enablers in use, and one resident has a bedside rail and chair lap belt in use as a restraint. Appropriate and safe use of restraint, as set out in policy, is implemented by the service. There is a process for determining restraint approval and ongoing education and competencies for staff.

Monthly evaluations are conducted for each individual restraint in use. Approved restraint is monitored according to risk. An annual audit of the use of restraint and policy content was undertaken in November 2016.

Infection prevention and control

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

The service`s infection prevention and control policies and procedures reflect current accepted good practice. Relevant education is provided for staff, and when appropriate, the residents.

There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where any trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	46	0	4	0	0	0
Criteria	0	95	0	6	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). The service policy states the Code is displayed and available to residents and monitored to ensure the rights of residents are respected. New residents and family/whanau are provided with a copy of the Code on admission. The admission pack was sighted and was well presented with all information required. The Code is displayed in all service areas in full view of residents, care staff and visitors.</p> <p>Staff receive training on the Code at commencement of employment as part of the orientation/induction process. Ongoing training was provided 25 October 2016. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice.</p> <p>The Code is made available in English, Maori and other languages for residents with English as a second language.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where</p>	FA	<p>Systems are in place to ensure residents, and where appropriate their family/whanau, are provided with appropriate information to make informed choices and informed decisions. A detailed informed consent policy is implemented. The registered nurses interviewed demonstrated a good understanding in</p>

<p>appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>relation to informed consent and informed consent processes. Family and residents interviewed confirmed they have been made aware of and understand informed consent processes and that appropriate information has been provided. Full explanations are provided by the registered nurse or the general practitioner.</p> <p>Different consent forms are utilised by the service provider and copies are retained in each resident's record reviewed. Advance directives are documented appropriately and signed off and dated by the general practitioner.</p> <p>The admission agreements were signed and dated by the provider and the resident and/or representative. The facility manager ensured these were all signed off and stored appropriately.</p> <p>Reviews of resident's individual health status is discussed and documented at the multidisciplinary team meetings held six monthly.</p> <p>Nursing management and registered nurses interviewed reported they received orientation/induction on the principles and practice of informed consent as part of the Code of Rights and provided evidence of an understanding of the Code. Ongoing training was provided in July 2016.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>The advocacy policy is available to guide staff and was reviewed in July 2016. The policy makes reference to the complaints procedure. All residents receiving care within this organisation have appropriate access to an independent advocate, including access to a cultural and/or spiritual advocate whenever required.</p> <p>Family/whanau interviewed reported they were provided with all relevant information regarding access to advocacy services. Choices are available and demonstrated. Contact details of the Nationwide Health and Disability Advocacy Service is listed in the resident information pack provided. Education for staff is conducted as part of the orientation programme and is ongoing. This was evidenced in the education programme and confirmed by the staff interviewed.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There is no set visiting hours and family are encouraged to visit. This is confirmed by family/whanau interviewed. Residents are fully supported and encouraged to access community services with visitors or part of the planned activities programme. Evidence was seen of this in the activity programme and reported by residents interviewed.</p> <p>The residents and families report that they take their family member out at least once a week for shopping or to the Returned Services Association (RSA) which is close to this home. here to enter text</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Woodfall Lodge implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system. During interview, residents, family/whānau and staff reported their understanding of the complaints process and reported any complaints made had been responded to in a timely manner. Staff confirmed they document verbalised complaints so all issues are accurately reflected and followed up by the facility manager.</p> <p>A complaints register is maintained and associated records verify complaints are investigated and responded to in a timely manner. Complaints information is used to improve services as appropriate. Complaints information is shared at staff meetings and with the directors if required / appropriate. This is confirmed in meeting minutes sighted and during staff, director and management interviews.</p> <p>Complaints forms are on display and available in the main entrance and included in the information pack given to new residents on arrival. The service also has a suggestion box which is checked regularly and complaints / feedback can be placed in this at any time.</p> <p>There was one complaint received via the District Health Board (DHB) in July 2016. This has since been closed as verified by an email sighted from the portfolio manager.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>A copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and the registered nurses go through the Code with the resident/family/whanau during the admission process.</p> <p>The family/whanau members that were available for interview reported that the Code was explained to them on admission. Interviews with residents who were able to provide insight into their care, expressed that they were treated with respect and dignity and were happy at the facility.</p> <p>There is an advocacy policy to guide staff. The provider and staff interviewed understand consumer rights.</p> <p>Evidence is seen of the Code of Rights being displayed throughout the facility and pamphlets were readily available at the entrance reception area. Staff displayed knowledge of the Code during interviews.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p>	FA	<p>The privacy policy requires the visual privacy and personal space of residents to be respected and observed at all times and that staff will facilitate the use of private space for interaction with visitors and others as required. The wishes of residents are acknowledged, sexuality and personal rights are</p>

<p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>upheld, and independence is maintained, maximised and encouraged.</p> <p>The residents` records reviewed indicated that residents received appropriate services that are responsive to their needs, values and beliefs of culture, religion and ethnicity.</p> <p>The families interviewed reported that their relatives were treated in a manner showing regard to the resident`s dignity, privacy and independence.</p> <p>The Salvation Army provided a church service weekly.</p> <p>As observed on the days of the audit and confirmed with review of the individual resident`s randomly selected records, residents receive services to meet their needs. No concerns were raised in relation to abuse and neglect from residents, family and/or staff interviewed. The GP was unable to be interviewed. Staff have received privacy training 10 November 2016 and Aged Concern education April 2016. Staff understood their responsibilities along with who to report to if abuse and or neglect was suspected with a resident and/or staff member. Comments received reflected a positive atmosphere from staff and family/whanau interviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The organisation has a Maori Health Plan developed for 2016 which acknowledges the primacy of the Treaty of Waitangi and states the service will provide an appropriate and effective health service for Maori people. Associate policies such as cultural awareness and recognition of individual values and beliefs ensure the service is committed to identifying the needs of the residents and ensuring staff are trained and capable of working appropriately with all residents in their care. The identification and reduction of any barriers are part of the organisation`s Maori Health Plan objectives. Maori health advisors are available and staff are aware of how to contact these individuals as required.</p> <p>Guidelines are developed and implemented to ensure guidance is available for the provision of culturally safe services for Maori residents. There are currently four residents who identify as Maori and nine staff who identify as Maori. The staff interviewed demonstrated good understanding of services that would need to be provided for Maori residents to meet identified needs and the importance of whanau.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural,</p>	<p>FA</p>	<p>A cultural needs assessment tool is available to ensure the identified needs can be effectively met. The spiritual, religious and cultural policies and procedures provide information to guide staff on correct protocol. The clinical manager and registered nurses have a good understanding of the four corner stones of Maori Health. Together these components blend to form an integral and comprehensive model of health and well-being for Maori residents.</p> <p>Staff interviewed reported they received training 1 August 2015 and cultural safety training is part of the</p>

spiritual values, and beliefs.		mandatory training annually. Staff interviewed recognised and respected these cultural needs in their everyday practices.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff records reviewed had employment agreements that had clear guidelines regarding professional boundaries. House rules are also part of the employment agreement and staff responsibilities were reviewed. All registered nurses have completed the professional boundaries workshops which is a requirement for the New Zealand Nursing Council. The family/whanau/residents interviewed reported they are pleased with the care provided.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The registered nurses promote and encourage best practice with staff. Evidence of this was demonstrated in interviews with the registered nurses. Some other examples of good practice are the accessibility of the Maori health advisors, infection control and use of a contracted service for additional reference material for infection control purposes. The introduction of 'Medimap' has had a positive impact on the medicine management for this service and registered nurses only are now responsible for medicine administration.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy which was reviewed in August 2015 which has another provider name on the policy. This has been addressed in 1.2.3.4 in regard to document control processes. The cultural awareness procedure documents that residents and families who do not speak English shall be advised of the availability of an interpreter/translation service, at the first point of contact with the service. The service promotes an environment that optimises communication and staff education related to appropriate communication methods. Family interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented in the residents' records reviewed, on the accident/incident form and in the residents' progress notes sighted.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and	FA	Woodfall Lodge has a documented mission statement, philosophy and values that is focused around the provision of individualised, quality care with dignity. The facility manager monitors the progress in achieving these goals via the internal audit process, review of resident and family satisfaction and via the quality meetings. The facility manager has an 'open door' for residents and families. A number of

<p>appropriate to the needs of consumers.</p>		<p>goals/objectives are set for the forthcoming year.</p> <p>The day to day operations and ensuring the wellbeing of residents is the responsibility of the facility manager. The owners also own and operate two other residential care facilities in Hamilton and Waipukurau. The manager from the Waipukurau facility has been appointed to a newly developed operations manager role. This is in addition to her facility manager role. The operations manager comes on site at least one day a week to support the Woodfall Lodge manager, and is also available by phone or email at any time. Another external consultant has assisted with project work since July 2016.</p> <p>The facility manager is an experienced registered nurse, and commenced on 16 August 2016 in a temporary capacity while a long term manager was recruited. This role has now been filled by the Woodfall Lodge RN / manager (refer to 1.2.2) who commences as facility manager on the 16 December 2016. This change has already been communicated to the portfolio manager at MidCentral DHB (MCDHB) and HealthCert as verified in emails sighted. The facility manager participates in relevant ongoing education as required to meet the provider's contract with MCDHB. The external consultant confirms she will continue to support the new facility manager for the next six months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The RN/manager has worked at Woodfall Lodge since May 2012 as a senior RN and temporary facility manager on occasions. She holds a current annual practising certificate (APC) and post graduate diploma in 'Advanced nursing - disease state management in the older age group', and participates in ongoing relevant education. The RN/Manager has been working with the temporary facility manager for the last month orientating to the permanent role of facility manager and will start from 16 December 2016 in this role. She is responsible for services in the manager's absence.</p> <p>The clinical nurse leader (CNL) is a RN with current APC and relevant aged residential care experience. She was employed in February 2016 and will be supporting the RN / Manager when she commences the facility manager role. The operations manager will continue to provide ongoing support.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>PA Low</p>	<p>Woodfall Lodge has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, health and safety reporting, infection control data collection and management, restraint and complaints management.</p> <p>If an issue or deficit is found a corrective action is put in place to address the situation. Corrective actions are developed and implemented and monitored for effectiveness. Quality information is shared with all staff via the handover process on each shift, in the staff communication diary, and in staff</p>

<p>principles.</p>		<p>meeting, the RN meeting, the quality meeting, and the Kaylex Care Ltd Skype managers' meeting (minutes sighted). This is verified during staff and manager interviews. Quality data is evaluated against previously collected data however is not currently being linked with the established quality indicators. Monthly meetings are held with residents to obtain resident feedback on services and future planning. Newsletters are distributed to residents and family from time to time.</p> <p>The policies reviewed reflected legislative and good practice requirements. Document control practices require improvement.</p> <p>Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management. Staff verbalised examples of quality improvements made such as the introduction of an electronic medicine management system in the last 14 months, and a full review of food services.</p> <p>Actual and potential risks are identified using the quality and risk planning processes and business continuity plan. Newly found hazards are discussed, monitored and managed via the quality committee. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard register sighted was up to date. The facility and operations managers and the Kaylex Care director interviewed were able to discuss the processes used to monitor risk and the changes in the organisation's risks.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Policy and procedure details the required process for reporting incidents and accidents. Staff are provided with education on the responsibilities for reporting and managing accidents and incidents during orientation and during discussions at staff meetings.</p> <p>Applicable events are being reported in a timely manner and also disclosed to the resident and or designated next of kin. This is verified by resident and family members interviewed. A summary of the reported events is maintained in each resident's clinical record. A review of at least seven reported events demonstrated that incident reports are completed, investigated and responded to in a timely manner. Changes were made to the resident's care plan where applicable or a short term care plan developed where applicable. Staff communicated incidents and events to oncoming staff via the shift handover. A summary of events are discussed with staff monthly at the staff meetings and at the quality meetings.</p> <p>The facility manager, operations manager and the RN / manager are able to identify the type of events that must be reported to external agencies. An essential notification was made in August 2016 and December 2016 to HealthCert and the DHB about the change in the person holding the facility manager role. A copy of these communications was sighted. Another notification was made when a resident was diagnosed with a fracture following a fall.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>The copy of the annual practising certificates (APCs) for the nine general practitioners (GPs), six pharmacists, and the seven registered nurses (RNs) were sighted.</p> <p>A staff education programme is in place. A training plan for 2017 and 2018 has been developed. A significant amount of education has occurred in the last five months. Records of education are maintained and copies of some education certificates are present in the staff files reviewed. In-service education and attendance records sighted demonstrated staff had access to regular ongoing education relevant to their roles and the service. A number of health care assistants are completing an industry approved qualification. The service is transitioning to a new training provider. A senior caregiver is an assessor.</p> <p>Records are not consistently available to demonstrate aspects of the recruitment process or that new staff have completed their orientation requirements within three months of employment.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider's contract with MidCentral District Health Board (MCDHB).</p> <p>The current roster was reviewed and demonstrated that there is a RN on duty 24 hours a day, seven days a week. Healthcare assistants work a variety of shifts, with start and finish times varied depending on the needs of residents and facility occupancy. Healthcare assistant hours have been recently increased. There are between four and seven caregivers on duty except for overnight when there are two health care assistants and one registered nurse on duty (between 10.45 pm and 6.45am). The facility manager, clinical nurse leader, receptionist / administrator, activities coordinator, and maintenance person are on site weekdays, and any clinical hours are additional to the rostered RN hours. Three RNs have completed interRAI training and competencies. One RN is in the process of completing the annual competencies.</p> <p>Additional staff hours are rostered for the cook and kitchen hand, and cleaning / laundry services every day including weekends.</p> <p>All caregivers interviewed report that there is adequate staff available and that they are able to get through their work. The staff confirmed the facility manager is available out of hours if required. The registered nurses have a current first aid certificate and these were sighted. The activities coordinator is booked to attend first aid refresher training early 2017 and confirmation of registration was sighted. In the interim activities are occurring on site.</p> <p>Residents and family members interviewed confirmed staffing meets their needs.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>There is evidence that resident information is collected and stored in accordance with the New Zealand Health Records Standard. A resident file is created prior to admission and essential information is entered on the day of admission (eg, medical conditions, medicines, next of kin and emergency contact numbers, initial assessments and the referral information). The front sheet of the record contains the unique personal identifying information, such as the consumers national health index number (NHI), date of birth, legal name, preferred name, past medical history, presenting medical and physical conditions, allergies/sensitivities, current general practitioner, ethnicity, birthplace, current support needs levels and gender.</p> <p>The current resident records are filed in the two reception areas in filing cabinets which are locked when not in use or unattended. Archived records of past and deceased residents are stored in a secure place.</p> <p>The residents` records sampled demonstrate that entries are legible and the writer of each entry signs their name, initials and designation. Records are integrated with information from all disciplines, external providers and medico-legal information.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has an admission enquiry form that records the pre-admission information. The DHB needs assessment service co-ordination service (NASC) is responsible for the pre-admission assessments and care level attainments. Residents` entry to service is by different avenues such as from home, DHB or another facility. There is a comprehensive information pack which is available for all new residents and/or their family/whanau. The service agreement is based on the Aged Care Association agreement which is individualised to the service. The residents` records reviewed have signed admission agreements by the resident/family or enduring power of attorney responsible for health and welfare.</p> <p>All residents at this facility have been assessed as either for rest home or hospital level care. A record of this assessment is in each record sighted. The admission agreement identifies any charges that are not covered by the service agreement and the relevant costs of each charge.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from</p>	<p>FA</p>	<p>Risks are identified prior to a planned discharge, as confirmed by interview with the clinical lead. A transfer form is used that identifies any risks. There is open communication between the service and family/whanau related to all aspects of care, including discharge or transfer. If there are any specific requests or concerns that the family or resident want discussed, these are noted on the transfer form. The discharge form and care plan summary is provided and covers all aspects of care provision and interventions required, including any known risks or concerns. Family contact details, medication record</p>

services.		with any allergies recorded, any advance directives also accompany the resident if they are transferred to hospital. The service uses the DHB's processes, envelope and forms, for the transfer process.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medicine management policy and procedures describe the processes to ensure safe administration of medications. The service has a policy that only registered nurses administer medications. All registered nurses have completed annual medication competencies. Sighted policies and procedures meet legislative requirements and best practice guidelines.</p> <p>Medicines for residents are received from the contracted pharmacy in a pre-packed delivery system. The registered nurses check the medications when delivered to the service. A safe system for medicine management is observed on the day of the audit. Controlled drugs are managed professionally with appropriate checks and balances recorded. An electronic recording system is used in practice for all medications administered. Medicines are stored in locked medicine trolleys and medicines that require refrigeration are stored in a separate fridge. Temperatures of the fridge are monitored daily.</p> <p>There is evidence of the three monthly reviews of medications being completed by the GPs. The clinical lead maintains a schedule which was sighted. The electronic records have photo identification for safety purposes. The registered nurses write a reason in the electronic records, if the resident is unable to take their medication.</p> <p>There are no residents that are self-administering their own medicines. A policy is in place should this situation arise.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>The food service policy and procedures are available to guide staff. All policies have been reviewed July 2016. There is a four week rotating menu with summer and winter variations. The menu plans have been reviewed by a registered dietitian 19 February 2016. Where unintentional weight loss is recorded, the resident is referred for a dietitian review. There is a main cook who works Monday to Friday and a cook is available for weekends and to cover the cook for any leave when required. There is a kitchen hand on to support the cook seven days a week.</p> <p>A nutritional profile is completed for each resident by the registered nurse on entry to the service. This information is shared with the cook to ensure all needs, wants, dislikes and special diets are catered for. There is food and nutritional snacks available 24 hours a day. On visual inspection, there is a whiteboard in the kitchen displaying any special diets.</p> <p>The family/whanau and residents reported they are satisfied with the food and fluid services. Cleaning schedules are available. The kitchen is clean and tidy and maintenance is in progress with the kitchen floor at the time of audit. Food service audits are completed and food satisfaction is included in the</p>

		<p>service surveys.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complies with current legislation and guidelines. Fridge and freezer temperature recordings are observed daily and records are maintained and were reviewed. Temperatures of the food are also monitored at time of serving. Verification of staff completing food safety training was not available.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The registered nurse reported that their service does not refuse the resident if they have a suitable NASC assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, family and NASC service would be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are assessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. An example would be if a resident required a secure dementia service the service would be unable to provide this service. The resident register would be updated if a resident is transferred to another care provider and the family/whanau kept well informed.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Initial assessments are performed on admission. The pre-admission interRAI assessment and/or admission details are taken into consideration and form the basis of the assessment. Assessments are undertaken by a registered nurse. The interRAI assessment is completed twenty one days after admission. All 32 residents have had an initial interRAI assessment and are reassessed six monthly or more often if required. A review schedule was provided by the clinical lead. There are three of seven registered nurses that are fully trained to perform interRAI assessments.</p> <p>The individual resident records reviewed have initial assessments that include identifying any risks relating to the particular resident. Additional recognised assessments are used such as continence assessment, wound care assessments and expertise is sought if required and a referral process is followed.</p> <p>The families interviewed reported their relatives receive excellent care that meets their relatives' needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated,</p>	FA	<p>The residents' records have care plans that address resident's current abilities, level of independence, identified needs/deficits, and takes into account the resident's habits, routines and idiosyncrasies. The strategies for minimising falls risk are based on the interRAI assessment and the use of techniques that are effective for the resident and these were evidenced in the records reviewed. The healthcare</p>

<p>and promote continuity of service delivery.</p>		<p>assistants interviewed demonstrated knowledge on the management of falls risks for residents.</p> <p>The care plans and the diversional therapy plans sighted in the residents` records reviewed identified the resident`s individual diversional, motivational and recreational requirements. The residents` records demonstrate integration and input from the multidisciplinary team. The medical records are electronically recorded by the GP and a hard copy is sent to be filed in the individual record after each visit.</p> <p>The clinical lead, registered nurses and healthcare assistants interviewed reported they receive adequate information to assist the continuity of care. The handover observed includes updates on all residents.</p> <p>The families reported a high level of satisfaction with the quality of care provided at this service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Clinical management policies and procedures includes assessment on admission, weight and bowel management, clinical notes and referral information. As observed on the days of the audit and from review of the care plans, support and care is flexible and individualised and focused on the promotion of quality of life. The clinical lead, registered nurses and healthcare assistants demonstrate skills and knowledge of the individual needs of residents. The residents` records showed evidence of consultation and involvement of the family. The residents interviewed reported satisfaction with the care and services provided.</p> <p>Short term care plans are used for any event that is not part of the care plan, such as for wound care management or to monitor falls or weight.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the residents` needs and set goals. Observations on the day of the audit indicated residents are receiving care that is consistent with their needs. The clinical lead interviewed reported that the care plans are accurate and kept up-to-date should any changes occur.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	<p>FA</p>	<p>The activities programme ensures resident`s individual cultural needs are recognised. The residents have opportunities to maintain interests they have developed within their lifetime and to develop new friendships in a caring environment. The trained diversional therapist is able to adapt activities to meet the needs and choices of residents.</p> <p>The weekly plan is available and displayed. All residents receive a copy. The programme is developed and implemented based on the resident`s needs, interests, skill and strengths. The healthcare</p>

<p>service.</p>		<p>assistants assist with the planned activities as able. The programme covers cognitive, physical and social needs. The diversional therapist interviewed reported that this gives the residents a sense of purpose, belonging and meaningful activities reflecting normal life interests.</p> <p>The service provides easy access to outside areas that enable the resident to wander safely. There is a courtyard that allows residents to wander safely. Van outings are provided and activities with other rest homes are provided.</p> <p>A daily attendance record is maintained and reviewed by the diversional therapist. The goals are update six monthly if needed. Where possible residents` independence is encouraged to maintain links with family and community groups. Families are encouraged to attend activities. Families interviewed take their relative to religious events and social events weekly.</p> <p>The family/whanau interviews reflected that their relative enjoys the range and variety of planned activities.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents` records reviewed have documented evaluations that are conducted within the required timeframes of six months or earlier if needed. Evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting set goals. If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with their GP. Residents` changing needs are clearly described in the care plans reviewed. The six monthly interRAI assessments completed by the registered nurses reflect outcomes of achievement or needs to be addressed. These processes are documented on the short term care plan, medical and nursing assessments and in the resident`s individual progress notes reviewed. The healthcare assistants interviewed demonstrated good knowledge of short term plans and reported that these are identified at handover.</p> <p>The families reported that they can consult with the staff at any time and by arrangement with the GP if they have any concerns or if there are changes in the resident`s condition.</p>
<p>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</p>	<p>FA</p>	<p>Residents are provided with options if required to access other health and disability services. There are nine general practitioners who visit this facility from the one practice. Residents have the choice of retaining their own GP. The GP`s arrange for any referrals when it is necessary. The clinical lead reported that the referral services are quite prompt in responding. Records of the process is maintained and confirmed in all residents` records reviewed. Referrals for a dietitian, mental health services, radiology, podiatry and other services were sighted in the records reviewed. The acting facility manager reported that appropriate referrals to other health and disability services are well managed at this</p>

provided to meet consumer choice/needs.		facility.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policies were sighted to detail how waste was to be segregated and disposed. The policy content aligns with current accepted practice.</p> <p>Chemicals sighted were stored in designated and secure areas. Material safety data sheets and wall safety charts detailing actions to take in the event of exposure were sighted for chemicals in use. Applicable staff have been provided with training on chemical safety and handling. There is a spill kit on site.</p> <p>Appropriate personal protective equipment (PPE) was available on site including disposable gloves, aprons, masks, and face protection. An emergency kit with PPE is also available for use in an outbreak or other significant event. The staff interviewed on this topic detailed what PPE was required to be worn by staff and when, in order to minimise risk of exposure to blood and other body fluids and contaminated items/equipment.</p> <p>Staff advised they would report inadvertent exposures to hazardous substances and blood and body fluids via the incident reporting system.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>There is a current building warrant of fitness (BWOFF) with an expiry 25 May 2017. Ongoing checks to maintain the BWOFF are occurring. An external company undertakes performance monitoring and electrical safety checking (where applicable) of clinical equipment. Evidence of this was sighted for clinical equipment checked at random. Electrical equipment sighted has evidence of current electrical testing and tag checks. Maintenance requests are identified and documented by staff when issues are noted. Requested tasks have been signed off as completed or are in progress.</p> <p>The facility vehicle has a current registration and warrant of fitness.</p> <p>There is a number of external chairs on the decks and outside that residents and family can use. Staff identified these areas are used more by residents during the warmer months. Residents were observed to be mobilising independently or with the use of a mobility device in their bedrooms and in communal areas. It was evidenced during the audit that temperature monitoring is currently not being performed at different sites around the facility. The television in the main lounge functions poorly and reception is not always available. Floor coverings are stained in several areas of the home and the bathroom linen supplies are inadequate and the linen is of poor quality.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Hand basins are present in each resident's bedroom. Waterless hand gel is also available for staff and residents at locations around the facility.</p> <p>There are six toilet /showers and five separate toilets that all residents are able to use. The caregivers interviewed confirmed there are enough bathroom and shower facilities for the residents' use as they assist or provide supervision for many of the residents when showering. Occupied / vacant signs are present on the bathroom and shower doors.</p> <p>There are separate bathroom facilities for staff use.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' bedrooms are single occupancy. The rooms contain space for the residents, personal possessions and use of mobility devices if required. Residents were sighted mobilising inside the rest home independently, including while using a mobility aid.</p> <p>The staff interviewed advised there is normally sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are two lounges and three separate dining areas that residents and their family or visitors can use. The residents and family members interviewed confirmed that there is sufficient space available for residents and support persons to use in addition to the residents' bedrooms.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Policies and wall mounted posters detail how the cleaning and laundry services are to be provided. Resident's personal clothing is washed and returned daily.</p> <p>The residents and family members interviewed confirmed the rest home is normally kept clean and tidy and residents' laundry is washed and returned in a timely manner. Audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated compliance with most aspects of the service requirements and remedial action where improvements were requested / identified. The resident satisfaction survey includes questions related to environmental cleanliness and laundry services. The feedback from residents is predominantly positive. Chemicals are stored in designated secure cupboards or in the sluice room. The wall mounted auto chemical dispenser is located in the</p>

		laundry. Two cleaners described the chemicals used for environmental cleaning during interview and these aligned with the wall mounted instructions. Instructions for managing emergency exposures to chemicals is readily available to staff. The chemical supplier monitors the chemical dilutions monthly and assesses aspects of quality and provides written reports.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The fire evacuation plan has been approved by the New Zealand Fire Service (NZFS) in a letter dated 21 August 2002. The most recent fire evacuation drill was conducted in November 2016 and the records were sighted.</p> <p>Policy documents provide guidance for staff on responding to other events, including (but not limited to) earthquake, flooding and volcanic eruptions. The current document was not available for staff (refer to 1.2.3.4). This topic is also included in the staff ongoing education programme.</p> <p>A review of the staff files and training records verifies that registered nurses have a current first aid certificate. Two caregivers interviewed detailed their responsibilities in the event of emergency.</p> <p>There are sufficient supplies available of dry food, lighting, a radio and batteries, and other clinical supplies for use in emergency. A BBQ for cooking is available along with spare blankets. A large water tank is onsite that refills with fresh water for use in emergency. Emergency lighting is available.</p> <p>Call bells are present in the bathrooms and residents' bedrooms. They alert audibly and a light also illuminates outside the room. Three call bells tested at random were fully functioning. Staff were observed to answer the call bells promptly.</p> <p>The caregivers interviewed advise the external doors and windows are checked and locked prior to dark. All external windows and doors are also checked and secured at this time, unless the resident wants their bedroom window left open. A door bell is present at the front entrance for family / visitors to ring after this time in order to gain access. No residents or family expressed any concerns about security.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms have a window and some have a door that opens onto a deck. Heating is centralised via underfloor or ducted heating depending on the area. Residents and family members interviewed verified the facility is kept suitably warm and ventilated. Smoking is only allowed in designated external areas. There are currently two residents who smoke.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service has a documented infection control programme which is reviewed annually. The infection prevention and control programme aims to minimise risk of infections to residents, staff, family/whanau and visitors to this facility. The organisation is a member of an external specialist infection control service. This service provides updates, guidelines and education on all aspects of infection prevention and control management. Reference and resource material is accessible to the staff.</p> <p>The infection control coordinator (ICC) role has recently been taken over by a senior registered nurse who is also the clinical lead. The ICC monitors all infections, uses standardised definitions to identify infections appropriately, and carries out surveillance. Monthly records are maintained. Infection control is presented at each staff meeting.</p> <p>The healthcare assistants are skilled and ensure they notify the registered nurses of any concerns when caring for residents. The shift handovers are also a forum for reporting infections. Short term care plans are used, for example for wound care and other infections.</p> <p>A process is identified in policy for the prevention of exposing others to infection. Staff interviewed knew when not to come to work and when to return. Signage is available and used when required. The ICC has set up two infection standard isolation boxes `ready to go boxes` and they are stored in readiness in the main store room. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Infection prevention advice can be sought from the GP, microbiologist, the specialist advisory service and from the DHB infection prevention and control team if and when required.</p> <p>The GP was not interviewed but the acting facility manager is well informed of obligations and reporting systems if needed for notifiable infection outbreaks of disease or illness. There has been no outbreaks of infection since the last audit. Guidelines and a pandemic plan are in place should an incident occur.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The clinical lead interviewed is the ICC and has only been in this role for a short time. The ICC is supported by one registered nurse and other staff are to be co-opted onto the committee after the next infection control meeting. External specialist advice is available if and when required through the GP, diagnostic contracted service and the DHB infection control team. Training is also provided by the external infection control provider and educational opportunities are available for staff to attend updates and study days.</p> <p>Training is also provided by the DHB for the ICC. The staff interviewed registered nurses and healthcare assistants interviewed demonstrated good knowledge and interest of infection prevention and control.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual was reviewed in July 2016. Woodfall Lodge Retirement Home has infection control policies and procedures to ensure good practice information is available to guide staff on how to prevent and manage the risk of infection and cross infection. The organisation is committed to providing appropriate resources to ensure the needs of the programme are met. References and appendices are used. The objectives of the infection control programme are clearly documented.</p> <p>The infection control manual is supported by the infection control procedures of an external specialist service`s resource manual which was sighted. Specific infection control areas such as methicillin resistant staphylococcus aureus (MRSA) and other antimicrobial screening, wound care management, blood and body spills management, cleaning and disinfectant are covered adequately. Laundry, kitchen and cleaning policies and procedures are developed and implemented specifically for this rest home and hospital service. Standard precautions are adhered to throughout all areas of service provision.</p> <p>Observations at the onsite audit identified the implementation of infection prevention and control procedures. Staff demonstrated safe and appropriate infection prevention and control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection control education is included in the orientation for all new staff and as part of the ongoing education training programme. Hand hygiene competencies are completed by all staff and the five moments of hand hygiene is promoted. Study days are planned and displayed on the staff notice board. Education evidence is available and was sighted on the day of the audit.</p> <p>The staff interviewed registered nurses, domestic staff and health care assistants demonstrated good knowledge of infection prevention and control. Resident education on infection control is provided in a manner that meets the various communication styles of residents. Any appropriate education provided would be recorded in the individual resident`s record for example for Hepatitis B or Methicillin resistant staphylococcus aureus (MRSA). Hand hygiene is always encouraged by all staff and management.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection control surveillance that is undertaken is adequate for the size and nature of this service. All staff are required to take some responsibility for surveillance activities as shown in policy. Monitoring is clearly described in the quality plan and management meetings, to describe actions to be taken to ensure residents` safety.</p> <p>The service monitors urinary tract infections (UTIs), eye infections, and upper and lower respiratory tract infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections. Results of surveillance are linked to the risk management programme. The monthly analysis of the infections includes comparison with the month before, reasons for the increase or decrease and actions taken to reduce infections. The analysis includes the feedback that is provided to staff on a two monthly</p>

		basis. Benchmarking is planned with other services owned by the organisation in 2017.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policy states that any form of restraint is a serious intervention and therefore every effort to minimise the use of restraint is made. Restraint is only applied to enhance or maintain the safety of the resident. The use of enablers is voluntary and the least restrictive option to meet the needs of residents. Health care assistants interviewed can clearly detail the differences between restraints and enablers.</p> <p>At the time of audit there are no enablers and one resident with two approved restraints (a bed rail and lap belt) in use. Restraints have been used for this resident's care for less than one month. There have been no other residents with restraints in use in 2016. One resident required restraints as a component of care in 2015. Staff actively work to minimise the use of restraint. Staff are provided with training on de-escalation techniques.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	FA	<p>Restraint approval and process as set out in policy are implemented by the service. There is a restraint committee and the resident (if possible), family/whanau and GP are always involved in the decision to apply restraint. This is confirmed in the resident's file reviewed. At the time of audit, the only restraints in use are a bedside rail and a chair lap belt.</p> <p>Restraint is reviewed if the resident's condition changes to determine if restraint is still appropriate and/or at least monthly. The family/whanau have signed to say restraint use has been discussed with them including the use of emergency restraint for 30 minutes, and the subsequent ongoing use of restraint.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint assessment/ checklist form is used to indicate if restraint is required. It covers all aspects of this criterion. There have been no reported incidents related to the use of restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Approved restraint is only put in place once alternative interventions have been considered. These interventions are documented in the residents' records. All restraint is approved by the restraint committee prior to being used, except in emergency. In this event, all approvals and communication</p>

		<p>occurs once the resident's safety has been ensured.</p> <p>The frequency of monitoring is undertaken according to the identified risk to the resident. When a lap belt was used for emergency restraint for 30 minutes, the resident was checked every 15 minutes for over five hours. Approvals for the use of emergency restraint and subsequently, the ongoing use of restraint was obtained the next day. The ongoing monitoring of this resident is occurring at least every thirty minutes as detailed in the resident's care plan. The family member interviewed was very supportive of the use of emergency restraint and ongoing use of restraint, to assist maintaining the resident's safety. The family member reports being kept fully informed by staff at all times.</p> <p>All restraints are detailed in the restraint register to an auditable standard.</p> <p>Staff interviewed confirmed their understanding and knowledge related to safe restraint use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>All restraint use is discussed at the quality and staff meetings as identified in minutes sighted. The continued use of restraint is reviewed monthly and this is to be documented in the resident's file. If restraint is no longer required, it is discontinued. Family/whanau are made aware of any changes in the need for restraint.</p> <p>The restraint committee review restraint procedures in the event restraint is utilised. This is documented in restraint committee meeting minutes sighted. The restraint coordinator is the clinical nurse leader, and monitors staff education to ensure staff have up to date knowledge and understanding of safe restraint use. Restraint education occurs during orientation and ongoing at least annually. The most recent education and competency assessment programme occurred between August and November 2016.</p> <p>An audit of restraint systems and process was undertaken in November 2016.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The quality committee review all restraint processes and usage at each meeting. Trends are shown using quality data which gives comparative data to previous restraint use. Care plans are regularly reviewed to ensure restraint use is clearly and correctly documented. If corrective actions are required they would be followed up by the restraint coordinator. The policies and procedures and staff educational content are fully reviewed via an audit, most recently in November 2016. This is shown in documentation sighted.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.4</p> <p>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.</p>	PA Low	<p>Policies and procedures are developed by one of the directors. Amendments to policy and procedure is only expected in the event there are unique reasons for amendments to be made. For example, the process related to warfarin management and dosing in MidCentral DHB is facilitated by the laboratory rather than general practitioners. Policies are available to the manager and the receptionist / administrator electronically. Documents are to be printed and available for staff in paper based manuals. Changes in policy are communicated via email or the fortnightly managers Skype meeting.</p> <p>Examples were sighted during audit where current electronic policies were not available for staff. The facility manager was unaware of the good employer policy (which includes staffing and skill mix requirements). A copy of this policy was not present in the policy manuals sighted. The 2015 business and continuity plan was printed. This had been updated in October 2016. The open disclosure policy</p>	Some current policies and procedures are not readily available for staff and managers.	<p>Ensure current policies and procedures are available for staff and document control processes implemented.</p> <p>90 days</p>

		noted the document was applicable to another Kaylex Care facility only.		
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	Satisfaction surveys and internal audits are being undertaken as scheduled and the results evaluated. Changes are made in practices and systems where applicable. The outcomes are not linked to the organisation's quality indicators / targets as detailed in the organisation's quality and risk plan.	The outcomes from quality monitoring activities, including satisfaction surveys and internal audits, are not being linked to the organisation's quality indicators as detailed in the quality and risk plan	<p>Ensure the outcomes from quality monitoring activities are linked with the organisation's quality indicators.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	Prospective staff are required to complete an application form, a health declaration, and undergo police vetting. Managers advise interviews are conducted and reference checks obtained. However, records are not available to consistently verify this process. The results of police vetting are not present for four out of eight staff files reviewed who were employed since February 2016. Records of reference checks and / or interviews are not present in five out of eight staff files reviewed, including four staff who were employed since July 2016. Staff have a job description and a signed employment agreement which includes a confidentiality/privacy statement on file. Performance appraisals are conducted at least annually and these were sighted in relevant staff files. A register is maintained to detail when these are next due.	The results of police vetting and records of reference checks and / or interviews are not present in some of the staff files reviewed for employees who commenced since February 2016.	<p>Ensure records are available to demonstrate that the recruitment process consistently includes reference checks, interviews and police vetting</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p>	PA Low	Staff are required to complete an orientation programme. This includes a checklist that is to be completed as relevant activities are	Records are not available to demonstrate that two out	Ensure records are

<p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>		<p>completed. The facility manager noted the expectation that new staff should complete the requirements within six weeks. Records evidencing completion of the orientation programme were not present in two out of four staff files reviewed for staff employed since July 2016, and who have been employed for at least three months. Staff interviewed report the orientation programme is thorough and includes at least three shifts being buddied with a senior staff member. The orientation included the facility, policy/processes, facility routine, staff tasks, and the individual resident's care needs.</p>	<p>of four staff employed since July 2016 have completed their orientation programme within three months of employment.</p>	<p>retained to demonstrate staff have completed orientation within the time frame set by Woodfall Lodge.</p> <p>90 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>All aspects of food procurement, production, preparation, storage, delivery and disposal complies with current legislation and guidelines. The cook is responsible for all ordering of food. The cook and weekend cook are reported to be experienced. The cook interviewed and the weekend cook state they have both completed food safety education but no records were available for review.</p>	<p>Records are not available to demonstrate that the two cooks have completed an industry approved food safety training programme.</p>	<p>Ensure records are available to verify that staff involved with food preparation and cooking have completed food safety training.</p> <p>90 days</p>
<p>Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the</p>	<p>PA Low</p>	<p>Grab rails are present in the resident showers. There are handrails in the corridors. The bathroom floors have non-slip linoleum floor covering. Some of the bathroom linen is in need of replacement. There was insufficient supplies readily available for staff. The need for new linen has been identified by the facility manager in the monthly report.</p> <p>The carpet in parts of the facility is heavily stained. Attempts to clean this in recent weeks have been unsuccessful. There is a hole in the</p>	<p>Some of the bathroom linen is needing replacement. There is insufficient supplies readily available. The carpet in parts of the facility is heavily stained. There is a hole in the floor in the laundry. The</p>	<p>Ensure the facility and supplies are fit for purpose and the temperature of hot water is monitored in</p>

<p>needs of the consumer/group.</p>		<p>floor in the laundry.</p> <p>The television in the resident lounge is not always working, Residents and family members interviewed identified they were unable to watch television when they wanted because the TV often did not work. The residents and family members interviewed confirmed the facility is otherwise furnished to create a home like environment and furniture was appropriate to the service setting. Residents have personalised their rooms as was observed.</p> <p>Monitoring is occurring on a monthly basis of the hot water temperature. The maintenance person selects at least two areas each month and tests the hot water temperature. Currently only hand basins in some residents' bedrooms are monitored, and the temperature of hot water in showers and bathroom facilities is not included. Some resident bedrooms have been checked more than once in the last six months, while other resident rooms are not tested. One shower checked at audit is just over 46 degrees Celsius.</p>	<p>television in the resident lounge is not reliably working, and monitoring of the hot water temperatures does not include all resident care areas.</p>	<p>resident care areas and is at or below 45 degrees Celsius.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.