

# Kaylex Care Limited - Eastcare Residential Home

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Kaylex Care Limited
<b>Premises audited:</b>	Eastcare Residential Home
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 4 April 2017      End date: 4 April 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	40

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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

Eastcare Residential Home provides rest home and dementia level care for up to 47 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the provider's contract with the Waikato District Health Board (WDHB).

Apart from changes within senior staff, there have been no changes to the scope and size of the service. One of the owners was acting in the role of facility manager on the day of the audit, and this will continue until a replacement facility manager commences.

Residents, a relative and a general practitioner interviewed on site expressed their satisfaction with the care and quality of services provided. There were no improvements required as a result of this audit.

## 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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The service demonstrates that it communicates effectively with its residents, their family members and allied health professionals when required, in a timely and open manner.

A complaints register is maintained. When complaints have been received, these are investigated and the information related to these is recorded. Residents said they had been informed about the complaint management process and felt supported to raise any concerns.

## 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.		Standards applicable to this service fully attained.
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The owner/acting facility manager is maintaining frequent and clear communication with all staff. The quality and risk management systems were being maintained with all areas of service delivery being regularly monitored. Adverse events were being reliably reported, and investigated to determine cause and prevention. People impacted by an adverse event were notified. The owner/facility manager understands the obligation to make essential notifications where required.

Staff were being recruited and managed effectively. Staff training in relevant subject areas has been occurring regularly. There were adequate number of skilled and experienced staff on site to meet the needs of each resident group.

## 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.		Standards applicable to this service fully attained.
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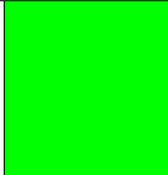
Residents` needs are assessed on admission within the required timeframes. There is a clinical nurse manager who is assisted by senior health care assistants and allied health staff as required. On call arrangements for support from senior staff are in place. Shift handovers and continuity of care is encouraged.

The care plans reviewed are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any problems that might arise. All residents` records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and family interviewed reported being well informed and input is sought for care planning and evaluation. The planned activity programme is overseen by the activities coordinator who provides with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings in the community.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using an electronic system. Medications are administered by the clinical nurse manager and/or senior health care assistants, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. The cook and staff have completed relevant food safety education. The menu plans have been reviewed by a dietitian in the last two years. The kitchen is well organised, clean and meets food safety standards. Residents and family verified satisfaction with meals.

## Safe and appropriate environment

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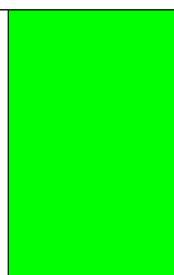
There is a current building warrant of fitness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service is not using restraint interventions and there were no enablers in use. Staff training on prevention of restraint has been occurring regularly.

## 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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Surveillance for infections is undertaken monthly. Results of surveillance is analysed to assist in achieving infection reduction. The infection surveillance results are appropriately reported to staff. Staff interviewed demonstrated a good knowledge of infection prevention principals and safe practice.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	0	39	0	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Records and staff and resident interviews showed that the service is managing all complaints received according to its policy and right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The complaints register and manager's reports state no complaints were received for 2015 and up to October 2016. There are five complaints received from October 2016 to March 2017. Residents confirmed knowledge of the ways to lodge a complaint. The complaints logged since the previous audit show that each matter was investigated immediately, and managed effectively for resolution with all parties. There was written evidence of ongoing communication with the people involved.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The service continues to promote an environment of good communication. Policies and procedures are in place if interpreter services are required. There were no non-English speaking residents on the day of audit. The GP and the family member interviewed said they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented on the accident/incident form and in the residents' progress notes sighted.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>On the day of audit there were 40 residents (14 rest home level, 24 dementia level and two people on respite). Five people were under the age of 65 years, three of these had long term chronic health care needs.</p> <p>The two owner/directors are currently managing the facility. Interviews and records sighted reveal there has been significant change in senior staff since the certification audit in April 2015. Two facility managers have resigned since September 2016 and a new manager is about to be appointed. A new clinical nurse manager was appointed five weeks ago and is still orientating to the role.</p> <p>The company (Kaylex Care Ltd) keeps current an overarching strategic/business and risk plan for the three facilities it operates. Each facility, including Eastcare, creates an annual business plan and this was sighted as having current goals. The documents reviewed and interviews with the owners show that the plans and the monthly quality management reports are currently being monitored and updated by the company's senior management team. This team comprise the two owners, a general manager and an operations manager.</p> <p>The owner/director is a registered nurse with a current practising certificate. This person confirmed they attend ongoing performance development in subject areas related to nursing and management. There is also ongoing liaison with other age care providers in the area and regular contact with relevant WDHB staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Eastcare is maintaining effective quality and risk management systems. Policies and procedures are updated as required to meet known best practice.</p> <p>Residents confirm they are consulted about any proposed changes in service and are being kept informed at regular residents' meetings.</p> <p>All quality data continues to be collated, analysed and shared at the facility managers' monthly 'Skype' meeting. Statistical and narrative data is displayed in the staff room, any events are communicated at handover, and unwanted trends are discussed at three monthly staff meetings. There is documented evidence of corrective actions on incident/accident reports, on the internal audit tools where a deficit or gap is identified, in the hazards register, and in complaints documentation. The service also completes quality improvement plans when service deficiencies or opportunities to improve are identified.</p> <p>The organisation's annual quality plan, business plan and associated emergency plans, document actual and potential risk to the business, service delivery, staff and/or visitors' health and safety. Health and safety policies are compliant with the current legislation and interviews confirmed that the owners understood their obligations. Environmental risks are communicated to visitors, staff and consumers as required through notices, or verbally, depending on the nature of the risk.</p> <p>Review of staff meeting minutes showed that health and safety including the hazard register and risks related to residents are discussed. The most recent fire drill occurred in February 2017 and another is scheduled for</p>

		June.
<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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analyzed and reported to the general manager, the owners and the other facility managers each month. The collated results and a narrative summary are displayed in the staff room. Staff confirmed that they are kept informed about incident and accident trends.</p> <p>The owner/acting facility manager described essential notification reporting requirements, including for pressure injuries. There has been one notification made to the Ministry of Health since the previous audit. A police search was initiated for a younger resident with challenging behaviour who went missing. There are multiple reported incidents related to this resident in the past three months, which the DHB are being kept informed about. Safer, more appropriate placement is in negotiation.</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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff working in the dementia care areas have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. For example, the younger high needs resident has 1:1 staff supervision. An after-</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>hours on call roster is in place, with staff reporting that ready access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and the family member interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All the care staff on duty have a current first aid certificate and there is and RN on call 24//7.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of the audit. The staff member observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacists input is provided on request.</p> <p>There are no controlled drugs stored at the facility. There is a locked cupboard within a cupboard if required. The medication fridge temperature is checked daily and recorded.</p> <p>The GP interviewed reviews all medications on admission for all residents and three monthly as recorded on the electronic records sighted. Any allergies/sensitivities are recorded for residents, as applicable, or 'nil known' is recorded on the electronic record and on the clinical hard copy records.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported on an incident form if this occurs and the incident management process is followed as protocol. Sample signatures are still maintained in the front of each resident's individual records.</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</p>	<p>FA</p>	<p>The food service is provided on site by an experienced cook and kitchen staff and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (19 February 2016). Recommendations made at the time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, are monitored appropriately and recorded as part of the plan. The cook has evidence of safe food handling qualifications being completed. All staff working in the</p>

<p>service delivery.</p>		<p>kitchen have completed related food handling and food hygiene requirements.</p> <p>A dietary profile is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to the kitchen staff and accommodated in the daily menu plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed who has been covering this facility for four years, verified that medical input is sought in a timely manner, that medical orders are followed, and care is managed effectively despite a change in clinical management since the last audit. Care staff confirmed that care was provided as outlined in the documentation. A range of resources was available, suited to the level of care provided in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by an activities coordinator currently employed part-time. An activities coordinator is commencing the week after this audit and the current activities coordinator will stay on with the same arrangements to provide support and activities as required. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities programme is discussed at the residents' meetings and indicated residents' input is sought and responded to as able, due to the nature of this service. Residents interviewed confirmed they find the programme enjoyable and especially the van outings to community activities as observed on the day of the audit.</p> <p>Activities for residents in the secure unit are specific to the needs and abilities of the people living there.</p>

		Activities are offered at times when residents are most physically active and/or restless. This includes a twenty four hour plan as sighted in the individual records reviewed. This approach has reduced the need for medication, improved appetite, anxiety levels and improved sleep patterns for some residents, as documented in the records reviewed.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress records. If any changes the health care assistants reported this to the senior healthcare assistant and/or the registered nurse on duty. There is a twenty four hour contact system for the clinical nurse manager/owner director(RN) and the GP if required.  Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents` needs change. Evaluations are documented by the registered nurse/clinical manager. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for accuracy and progress evaluated as clinically indicated each shift and according to the risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expiry date December 2017) is publicly displayed. There have been no changes made to the building since the previous audit.
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	FA	Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented on the infection reporting form. The clinical nurse manager interviewed collates the information by type of infection and the total number of infection incidents and the monthly summaries are sent to the owner/director (RN). Internal benchmarking occurs with the organisation's other facilities and graphs are provided and were reviewed.  Any new infections and/or any required management plans are discussed at staff handover to ensure early

programme.		interventions occurs. Surveillance results are shared with the staff at the staff meetings.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policy and procedure for restraint minimisation identifies and describes restraint and enablers. The service does not use restraint in its practice but there is a process should this occur. No enablers were in use with any resident in the service at the time of audit.

## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.