

Lexhill Limited - Kaikohe Care Centre

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

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

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

The specifics of this audit included:

Legal entity: Lexhill Limited

Premises audited: Kaikohe Care Centre

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

Dates of audit: Start date: 21 August 2017 End date: 22 August 2017

Proposed changes to current services (if any): The service provides hospital- geriatric level care and this is currently not on their certificate.

Total beds occupied across all premises included in the audit on the first day of the audit: 50

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

Kaikohe Care Centre is certified to provide rest home, hospital (geriatric and medical) and dementia level of care for up to 55 residents. On the day of the audit there were 50 residents living at the facility. An experienced and qualified facility manager, who is a registered nurse, manages the service. Residents and family interviewed were complimentary of the staff.

This certification audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff, management and general practitioner.

This audit identified improvements required around quality improvement data, corrective action planning, staff orientation, education and training, staffing levels, admission agreements, service provision timeframes, service delivery plans, medication management, reactive maintenance, first aid training and call bells.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. The facility manager and a clinical nurse manager are responsible for the day-to-day operations of the care facility.

Quality and risk management processes are established. Strategic plans and quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements.

An orientation programme is in place for new staff. A staff education and training programme is in place.

Registered nursing cover is provided twenty-four hours a day, seven days a week. The residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The care plans are resident and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall residents' files. There is a three-monthly general practitioner review. Residents interviewed confirmed that they were happy with the care provided and the communication.

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

Activities provided are appropriate to the resident's assessed needs and abilities.

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

Safe and appropriate environment

<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 medium or high risk and/or unattained and of low risk.</p>
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Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness.

Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system.

Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	42	0	2	6	0	0
Criteria	0	90	0	3	8	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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 Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. The policy relating to the Code is implemented and eight care staff interviewed (five caregivers, two registered nurses (RNs) and one diversional therapist) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme (link to finding 1.2.7.5).</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are policies in place for informed consent and resuscitation and the service is committed to meeting the requirements of the Code. There were signed consents on all eight residents' files sampled. Advance directives were appropriately signed in the files reviewed.</p> <p>Discussions with staff confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. Discussions with residents confirmed that the service actively involves their relatives in decisions that affect their lives, where they consent to this.</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>	FA	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) office is included in the resident information pack that is provided to new residents and their family on admission. HDC advocacy brochures are also available. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.</p> <p>Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service (link to finding 1.2.7.5).</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>	FA	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are available at the entrance to the facility.</p> <p>Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints.</p> <p>A complaints register is maintained. Five complaints have been lodged in 2017 (year-to-date). All five complaints were reviewed. Evidence was sighted to confirm that each complaint had been managed in a timely manner including acknowledgement, and a comprehensive investigation. One complaint (received 7 August 2017) is open and the remaining complaints are documented as resolved.</p> <p>Complaints received are linked to the quality and risk management system (link 1.2.3.6 and 1.2.3.8).</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information folder that is provided to new residents and their families. An RN discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings. All nine residents (five rest home and four hospital) and three family (two dementia and one hospital) interviewed, reported that the residents' rights were being upheld by the service.</p>

their rights.		
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' personal belongings are used to decorate their rooms. One hospital and one rest home level room have full ensuites. Privacy signage is on communal toilet and shower doors. Curtains are installed for visual privacy in shared rooms. Residents and family must first consent before occupying a shared room.</p> <p>The caregivers interviewed, reported that they knock on bedroom doors prior to entering rooms, ensure doors or curtains are shut when care is being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and families interviewed confirmed that residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service (link to finding 1.2.7.5).</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>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. Māori signage is posted throughout the facility. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. There were four residents living at the facility who identified as Māori.</p> <p>Specific Māori cultural needs are identified in Māori residents' care plans. One Māori resident interviewed (rest home level) reported that their cultural needs were being met by the service.</p> <p>Māori consultation is available through links with Māori community organisations. A kaumātua has been appointed and has been teaching Te Reo language classes for the residents. Several care staff identify as Māori. Staff education on cultural awareness begins during their induction to the service and continues annually (link to finding 1.2.7.5). The caregivers interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service.</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, spiritual</p>	FA	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans, evidenced in all eight care plans reviewed. Residents and families interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>

values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries and the code of conduct are discussed with each new employee during their induction to the service, evidenced in all eight staff files reviewed. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>A registered nurse is available 24 hours a day, seven days a week. A general practitioner (GP) from the local medical centre visits the facility twice weekly. Residents are reviewed by a general practitioner (GP) every three months at a minimum.</p> <p>Resident/family meetings are held monthly, led by a diversional therapist. Residents and families interviewed reported that they were satisfied with the services received, although reported that they were not satisfied with current staffing levels (link 1.2.8.1). A resident/family satisfaction survey is completed annually (link 1.2.3.6 and 1.2.3.8). The service receives support from the district health board (DHB), which includes (but is not limited to) specialist visits (e.g., infection control specialist, psychiatry for older persons (POPS), mental health and addiction services). Physiotherapy services are accessed as needed. A van is available for regular outings.</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>An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a range of information regarding the scope of services provided to the resident on entry to the service, and any items they have to pay for that are not covered by the agreement. Regular contact is maintained with families including when an incident or care/health issues arises, evidenced in the 15 accident/incident forms that were randomly selected for review. Interviews with families confirmed that they are kept informed. The information pack is available in large print and can be read to residents.</p> <p>Interpreter services are available through the DHB if required. The facility manager reports that this has not been necessary. There were no residents at the facility who did not speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures</p>	FA	<p>Kaikohe Care Centre provides rest home, hospital (geriatric and medical) and dementia levels of care for up to 55 residents. On the day of the audit there were 50 residents in the care centre (22 at rest home level, 21 at hospital level and 7 at dementia level). One resident was on respite (hospital level) and one resident was on ACC (hospital level). Originally the service was certified for 61 rooms' but six rooms are not currently</p>

<p>services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>being used. The service has plans to refurbish these rooms and utilise them.</p> <p>An experienced facility manager is responsible for day-to-day operations. She had been a previous facility manager at this facility (2006-2011) and resumed responsibilities as the facility manager in June 2017. She is a registered nurse with a current practising certificate.</p> <p>Business goals are in place with evidence of regular reviews. The facility manager meets regularly with the owner.</p> <p>The facility manager has attended a minimum of eight hours of professional development activities related to managing an aged care facility. Her induction in June 2017 was over a period of one week, conducted by the previous facility manager.</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 clinical nurse leader (CNL)/registered nurse (RN) is responsible for the care centre during any absence of the facility manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>A quality and risk management programme is documented. Quality is overseen by the facility manager. Policies and procedures have been established with the assistance of an external consultant. Policies have recently been updated to address DHB concerns relating to the management of ostomies, and urinary catheters. Policies and procedures reflect evidence of reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, and skin tears and pressure injuries. The majority of data was collated but was not analysed, or evaluated and results were not communicated to staff. Plans are in place to benchmark results against other Northland aged care facilities.</p> <p>An internal audit schedule is in place with evidence of audits being completed as per the audit schedule. Documentation does not support the implementation of corrective actions where opportunities for improvements were identified. Furthermore, corrective actions are not discussed with staff as evidenced in</p>

		<p>the meeting minutes.</p> <p>Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls, sensor mats and the availability of physiotherapy services.</p> <p>The health and safety programme meets current legislative requirements. It is overseen by a health and safety officer who is the maintenance officer. A health and safety induction programme is in place. Hazard identification forms and a hazard register are in place.</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>	FA	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events, which is linked to the quality and risk management system (link 1.2.3.6 and 1.2.3.8). Immediate actions taken are documented on accident/incident forms. The forms are reviewed and investigated by an RN. If risks are identified, these are processed as hazards and are reported in the staff/quality meeting. Neurological observations are completed if there is a suspected injury to the head.</p> <p>Discussions with the facility manager confirmed her awareness of statutory requirements in relation to essential notification.</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>	PA Moderate	<p>Job descriptions are in place that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses and other health professionals were current. Eight staff files were reviewed (four caregivers, one clinical nurse leader/RN and three staff RNs). Evidence of signed employment contracts and job descriptions were sighted. Annual performance appraisals for staff were behind schedule. Newly appointed staff are scheduled to complete an orientation that is specific to their job duties. Evidence of this occurring was missing for a sample of staff files reviewed.</p> <p>The service has a training policy and schedule for in-service education. Caregivers working in the dementia unit who have been employed for over one year have their dementia qualification. In-service education continue to reflect low attendance rates.</p> <p>Competencies for RNs include medication and syringe driver.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	PA Moderate	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. An RN is scheduled 24 hours a day, seven days a week. Caregiver staffing had been reduced over the past two months and had resulted in staffing issues for rest home level of care.</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>Separate cleaning and laundry staff are available five days a week. Activities staff, rostered five days a week, are dependent on caregiver availability. If a caregiver is unavailable, a diversional therapist fills this gap.</p> <p>Staff interviewed reported that staffing levels and the skill mix was unsafe for rest home level residents. Interviews with residents and families confirmed that the caregivers in the rest home were not able to meet the residents' needs in as timely of a manner as compared to staffing before staffing hours were reduced.</p> <p>The facility manager reported that the roster is able to be changed in response to resident acuity.</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>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area.</p> <p>Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant caregiver or nurse, including designation.</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>PA Low</p>	<p>The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements were not all signed in all resident's sampled records. Admission agreements reflect all the contractual requirements. Residents reported that the admission agreements were discussed with them in detail by the manager. All residents had the appropriate needs assessments prior to admission to the service. The facility manager, a registered nurse, ensures that residents are admitted to the service as per contractual requirements.</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 services.</p>	<p>FA</p>	<p>A standard transfer notification form from the district health board is utilised when residents are required to be transferred to the public hospital or to another service. The CNL verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine</p>	<p>PA</p>	<p>The service uses individualised medication blister packs which are checked on delivery by a registered</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>Moderate</p>	<p>nurse. Two registered nurses and medication competent caregivers were observed administering medications correctly in each area. The facility utilises medication charts and signing sheets to record prescribing and administration of medications.</p> <p>Resident photos were attached to all medication charts reviewed. Known allergies or no allergies were consistently documented. Medications are reviewed three-monthly with medical reviews by the attending GP.</p> <p>An annual medication administration competency was completed for all staff administering medications and medication training had been conducted. Current medication competencies were evidenced in the staff files.</p> <p>There were two residents who self-administered medications. The self-administration policies and procedures were in place and both residents had a secure drawer for storage of medication in their bedroom. Self-medication competencies had been completed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. The head cook oversees the provision of food services. A second cook and two kitchenhands provide cover across a seven-day service. All meals are prepared and cooked on-site. All kitchen staff had food safety training. There is a six-weekly seasonal menu. An audit of the menu was completed by a NZ dietitian in 2016.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. The registered nurse completes the dietary requirement forms on admission and provides a copy to the kitchen. Additional or modified foods are also provided by the service. Cultural needs are catered for.</p> <p>Fridge and food temperatures were monitored and recorded weekly. Cooked meals are transferred into heated bain maries and transported from the kitchen directly to the dining rooms. The residents interviewed confirmed that they are provided with alternative meals as per request. All residents are weighed monthly. Residents with weight loss problems are provided with food supplements.</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</p>	<p>FA</p>	<p>There is a documented policy, which outlines the process for declines of entry to service. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined. The district health board needs assessors and social workers contact the facility manager to discuss the suitability of the potential resident prior to sending the potential resident and their family to view the facility.</p>

by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The registered nurses utilise standardised risk assessment tools on admission and the interRAI assessment tool. Six of seven (one ACC) long term resident files included interRAI client assessment protocols (CAPs), and interRAI assessment summary forms. These long-term files also had a current interRAI assessment, however not all interRAI assessments were completed within 21 days (link 1.2.7.5), and not all care plan interventions reflected current resident needs. (Link to 1.3.5.2 for care plan interventions). Cultural, sexuality and intimacy needs have been identified for the residents.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Service delivery plans demonstrated service integration. Assessments and care plans include input from allied health. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. The long-term care plans reviewed do not always describe the support required to meet the resident's goals and needs. Not all long-term resident files had a documented LTCP to guide care and short-term care plans are not always in use for changes in health status.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Residents interviewed confirmed care delivery and support by staff is consistent with their expectations. The residents interviewed expressed satisfaction with the clinical care and that they are involved in the care planning. Caregivers interviewed stated there is adequate equipment provided including continence and wound care supplies. On the day of the audit supplies of these products were sighted. The service maintains close links with mental health services. There were three pressure injuries being treated at the time of the audit. Three skin tears were the other wounds currently being treated. The two registered nurses and CNL interviewed could describe the referral process to a wound specialist or continence nurse. Monitoring occurs for weight, vital signs, blood glucose and challenging behaviour. Caregivers interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions at the beginning of each shift.

<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>	FA	<p>The service employs two diversional therapists across five days a week (link 1.2.8.1). The two diversional therapists interviewed displayed an understanding of requirements. All activities are supported by caregivers.</p> <p>The weekly activities are posted on a large whiteboard in the main hallway and on resident noticeboards in each area and include outings, baking, table tennis, bowls, bingo, church services and quizzes. The diversional therapy plans sampled reflected the resident's preferred activities and interests. Each resident has an individual activities assessment on admission and from this information an individual diversional therapy plan is developed. The diversional therapy plan evidences review at six-monthly at the multidisciplinary meetings. The reviews document the resident's progress towards meeting goals; however, five of seven diversional therapy plans reviewed did not document interventions towards achieving the residents' desired goals (link to 1.3.5.2). The resident's activities participation log was sighted. Residents interviewed indicated the activities provided by the service are adequate and enjoyable. On the day two of audit, some residents were observed being actively involved. There was DVD sing-a-long playing for the resident's in the Ward and Housie in the Puriri Lodge. They also had Arts and crafts going (Monday) the following day Tuesday, was a church group visiting all three areas, plus a knitting group and crossword challenge group games.</p> <p>Activities provided are appropriate to the needs, age and culture of the residents. Caregivers support all activities. A volunteer supports four days per week.</p> <p>The DT's develop a programme for the facility and there is close liaison with each other to ensure residents can attend entertainment or activities happening in any area. Activities assessments reflected the residents preferred activities and interests (including spiritual and cultural preferences and capabilities) and are considered in the delivery of the service. The resident's individual activities record were sighted. Caregivers were observed at various times through the day diverting residents from behaviours.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans were evaluated by the RN within three weeks of admission. Long term care plans are evaluated six monthly and when a change occurs (link 1.3.5.2). The GP reviews residents at least three monthly or when there is a change in health status. The family members interviewed confirmed they are invited to attend the GP visits and multidisciplinary care plan reviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	FA	<p>There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and families are kept informed of the referrals made by the service. Internal referrals are facilitated by the CNL or registered nurse.</p>

<p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<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>	<p>FA</p>	<p>All chemicals were securely stored. Storage areas both inside and outside were locked. Chemicals were clearly labelled and safety material datasheets were available and accessible in all service areas. Staff interviewed confirmed they can access personal protective clothing and equipment at any time. As observed during the audit, staff were wearing gloves, aprons and hats when required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. The facility has a current building warrant of fitness (expires 30 June 2018). The fire evacuation scheme document reviewed was approved 25 June 2007.</p> <p>A new call bell system was recently installed (link 1.4.7.1). Maintenance is undertaken by both internal maintenance and external contractors. Electrical safety test tag system shows this has occurred last in June 2017. Some areas requiring maintenance were observed during the audit. The maintenance person advised that in areas requiring general maintenance, arrangements had been made for these to be completed. Documentation was sighted which supported that maintenance was to be completed. All maintenance records reviewed are clearly documented and where issues were identified corrective actions had been completed. Review of the records reveals water temperatures are all below 45 degrees Celsius and whenever it was out of range, corrective actions had been taken.</p> <p>All external areas inspected are safe and include appropriate seating and shade. The lounges are carpeted or have vinyl floor coverings, dining rooms and hallways have vinyl floor covering, bedrooms have a mix of carpet and vinyl. The front outdoor area has a tarmac and gravel driveway with grassed areas and flower beds.</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>One rest home and one hospital room have an ensuite and others share communal toilets and showers. There were sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities were available. Residents interviewed stated their privacy and dignity were maintained while attending to their personal cares and hygiene. The communal toilets and showers are well signed and identifiable and include vacant/in-use signs.</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>The resident rooms were spacious enough to meet the assessed resident's needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient area to allow cares to take place. The bedrooms are personalised.</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 large lounges, activity rooms and dining rooms in the rest home and hospital areas. The lounge and dining areas in the protected living environment (dementia unit) are homely and easily accessible to all residents. Residents in all areas have access to smaller quiet lounges. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer groups. Residents interviewed reported they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges. During the audit residents were observed sitting in the covered decking areas and engaged in craft activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning</p>	FA	<p>Dedicated domestic staff are responsible for cleaning and laundry service. There are sufficient staff allocated seven days a week to carry out these services. The service conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. Chemicals are stored appropriately in locked cabinets at all times. Material safety datasheets are available. Cleaner's trolleys are</p>

<p>and laundry services appropriate to the setting in which the service is being provided.</p>		<p>stored in a locked room when not in use.</p>
<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>	<p>PA Moderate</p>	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills are scheduled every six months. The orientation programme and annual education and training programme include fire and security training (link to finding 1.2.7.5). Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A power generator and gas barbeque are available.</p> <p>The call bell system has recently been upgraded. Residents were observed in their rooms with their call bell alarms in close proximity but a selection of rooms did not have call bell cords for ease of access. The rest home area showers also do not have suitable access to call bells.</p> <p>There is a minimum of one staff available seven days a week with a current first aid/CPR certificate on the am and pm shifts but not on the night shift.</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>	<p>FA</p>	<p>All communal areas and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service</p>	<p>FA</p>	<p>Kaikohe Care Centre has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The CNL is the designated infection control nurse with support from all staff. Infection control matters are routinely discussed at staff meetings. Education has been provided for staff. The infection control programme has been reviewed annually.</p>

providers, and visitors. This shall be appropriate to the size and scope of the service.		
<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>	FA	<p>There are adequate resources to implement the infection control programme. The infection control (IC) nurse has maintained their practice by attending registered nursing updates via external education. The infection control team is all staff through the IC committee (IC nurse (CNL), facility manager, caregiver representatives). External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and hand sanitisers are freely available.</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>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two yearly.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and</p>	FA	<p>The staff orientation programme includes infection control education. The infection control nurse has completed infection control updates and provides staff in-service education last completed August 2017 (link 1.2.7.5). Education is provided to residents in the course of daily support with all residents interviewed able to describe infection prevention practice that is safe and suitable for the setting.</p>

consumers.		
<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>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The infection control nurse and facility manager collate information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Surveillance of all infections is entered onto a monthly summary and then analysed and reported to RN and CQI meetings. Annual infection control reports are provided. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule and have been completed as per the schedule. The infection rate is low and there have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. Five residents (hospital level) were using bedrails as restraints and two residents (hospital level) were using enablers.</p> <p>One file of a resident using bedrails as an enabler was reviewed. Documentation met all requirements of the restraint standard for enabler use.</p> <p>Staff receive mandatory training around restraint minimisation (link to finding 1.2.7.5). In addition to in-service training, staff are requested to complete restraint competency questionnaires (sighted for 2017).</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>A restraint approval process and a job description for the restraint coordinator are in place. Restraint minimisation policies and procedures describe approved restraints. An RN is the designated resident coordinator.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure</p>	FA	<p>The restraint coordinator is responsible for assessing a resident's need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family, and</p>

rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.		<p>observations by staff. A restraint/enabler assessment tool is being implemented.</p> <p>Two hospital level residents' files where restraint was being used were selected for review. Each file included a restraint assessment which included the identification of any risks associated with the use of restraint. Restraint use was linked to the resident's care plan in both residents' files reviewed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>A restraint register is in place. The register identifies the residents that are using a restraint, and the type of restraint used. Five hospital level residents were using restraints. The restraint assessments reviewed identified that restraint is being used only as a last resort.</p> <p>The frequency of monitoring residents while on restraint is documented. Residents using restraints and enablers were being monitored every two hours. Monitoring forms are completed when the restraint is put on and when it is taken off.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Restraint use is reviewed three-monthly by the restraint coordinator, meeting requirements of the standard. Restraint use is discussed in the RN meetings and staff meetings.</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 restraint programme, including reviewing policies and procedures and staff education is evaluated as evidenced in the document control for restraint policies and procedures, in the meetings minutes and in discussions with the facility manager and restraint coordinator.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>The monthly collating of quality and risk data includes (but is not limited to) residents’ falls, infection rates, and skin tears and pressure injuries. The majority of data was collated but was not analysed, or evaluated and results were not communicated to staff. Plans are in place to benchmark results against other Northland aged care facilities. Internal audits are completed but outcomes not communicated to staff. An internal audit schedule is in place with evidence of audits being completed as per the audit schedule. Documentation does not support the implementation of corrective actions where opportunities for improvements</p>	<p>(i) Since June 2017, meeting minutes do not reflect internal audit results being communicated to staff.</p> <p>(ii) Results from the 2017 satisfaction survey, completed earlier in the year, have not been collated to identify trends.</p> <p>(iii) Clinical indicator data has not been evaluated since June 2017.</p>	<p>(i) Ensure audit results are communicated to staff.</p> <p>(ii) Ensure data that is collected from satisfaction surveys are collated, evaluated and used for service improvements.</p> <p>(iii) Ensure clinical indicator data is evaluated to identify areas for improvements.</p>

		were identified (link 1.2.3.8).		90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Processes around documenting and implementing corrective actions are not embedded into practice. An internal audit schedule is in place with evidence of audits being completed as per the audit schedule. Documentation does not support the implementation of corrective actions where opportunities for improvements were identified</p>	<p>i) No corrective actions were developed around satisfaction survey results for 2017 (e.g., four of ten survey results identified that residents were unhappy with the food).</p> <p>ii) The corrective action plans identified from internal audits that have taken place since June 2017, have not been implemented. For example, three internal audits indicated that issues identified would be discussed in staff meetings but meeting minutes do not reflect any evidence of discussions taking place.</p>	<p>i) Ensure corrective actions are developed from satisfaction surveys that address negative trends in data.</p> <p>ii) Ensure that corrective actions identified from internal audits are implemented.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Moderate	<p>(i) The clinical nurse leader, who has been in this role for two months, reported that she has not undergone any orientation to the role.</p> <p>(ii) In addition to the clinical nurse leader's human resources file, three further staff files (one caregiver, two RNs) of eight reviewed, were missing evidence that they had completed their orientation programme. Interviews with the caregivers and staff RNs confirmed that an orientation programme had taken place. The facility manager reported that staff are forgetting to submit their completed induction paperwork for filing.</p>	<p>(i) The clinical nurse leader has not had an orientation specific to her role.</p> <p>(ii) Three further staff files (of eight staff files) were missing documented evidence of staff completing their orientation programme.</p>	<p>(i) Ensure that the clinical nurse leader is orientated to her new role.</p> <p>(ii) Ensure that staff files contain documented evidence that they have completed their induction programme.</p> <p>60 days</p>

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>An education and training programme is being implemented but staff reported that they are either unable to attend due to high workloads or are unable to attend because it is their day off work. Contractual obligations regarding staff attendance at education and training are not being met. A plan was established following the last (provisional) audit (one year ago) to implement strategies to address this issue but strategies have not been implemented.</p> <p>Nine caregivers work in the dementia unit and all nine have completed their dementia qualification.</p> <p>There are currently only two RNs interRAI trained and two in training. The service has struggled to keep up with meeting contract requirements.</p>	<p>(i) Fifty-three staff are employed by the service. The 2017 in-service education and training provided for staff reflected low attendance rates with attendance consistently below 50%. Only two of eight staff files reviewed indicated that they had maintained eight hours per year of education. The facility manager plans to begin in-service training during handovers but reports that she has not implemented this initiative yet. (ii) The service has struggled ensuring enough interRAI trained staff to meet contractual requirements (Three long term resident files (two hospital and one dementia) reviewed did not have an interRAI assessment documented within twenty-one days).</p>	<p>(i) Ensure staff attend all mandatory education and training and can demonstrate that they have each attended eight hours annually as per the aged related care (ARC) contract. (ii) continue to access interRAI training for RNs to ensure contract timeframes are met for assessments.</p> <p>60 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>In addition to the facility manager/RN (Monday – Friday) and clinical nurse leader/RN (Monday – Thursday) an RN is on-site 24 hours a day, seven days a week. The RN is based in the hospital wing (occupancy 21) and covers all three wings including the rest home (21 residents), and dementia (7 residents). There are three caregivers rostered on the night shift (one rest home, one hospital, one dementia).</p>	<p>(i) A recent cut in staffing levels two months ago, reflects that caregiver staff in the rest home wing struggle to meet the current needs of the residents on AM and PM shifts. Only one caregiver is rostered for 21 residents. Three rest home level residents require two assists. Caregiver staff in the hospital wing are reported as frequently being too busy with hospital level residents to assist with the rest home level residents. This shortage in staffing was confirmed in staff and residents' interviews.</p> <p>(ii) Activities staff fill in for caregiver staff during caregiver absences, resulting in no activities for</p>	<p>Ensure staffing is adjusted to meet the current needs of the resident.</p> <p>(ii) Ensure the residents in all areas receive an activities programme that meets their needs</p>

		<p>Three caregivers (two long and one short shift) cover the hospital wing during the AM and PM shifts and only one caregiver covers the rest home during the AM and PM shifts. This is a reduction of one caregiver. The caregiver working in the rest home is instructed to contact the hospital staff if they need assistance but report that often caregiver staff are not available. There are three rest home level residents who required two assists.</p> <p>Activities staff are used to cover caregiver absences resulting in the shortage of staff for the activities programme.</p>	<p>residents. During the audit, it was noted on day one that there was no activities programme for the residents' due to this issue.</p>	<p>30 days</p>
<p>Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	<p>PA Low</p>	<p>Pre-admission information packs include information on the services provided for resident and families. Admission agreements for long-term residents aligned with contractual requirements. Exclusions from the service are included in the admission agreement.</p>	<p>Three of eight files (one rest home and two hospital including one respite) did not have signed admission agreements.</p>	<p>Ensure there is a signed admission agreement on file for all residents.</p> <p>30 days</p>
<p>Criterion 1.3.12.1 A medicines management</p>	<p>PA Moderate</p>	<p>A medication management system is in place. Staff medication competencies are completed annually and were evidenced in staff files</p>	<p>(i) Two of sixteen medication chart signing sheets reviewed (dementia care) evidenced that medications had not been administered as prescribed. (ii) One medication chart (dementia resident) did not</p>	<p>(i) Ensure that all medication has been given as prescribed.</p>

<p>system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>reviewed. The GP reviews the medication chart when completing three monthly medical reviews. Thirteen medication charts reviewed evidenced that medications had been administered as prescribed.</p>	<p>document the signature of the prescriber for one regular medication administered and one of two hospital medication signing sheets reviewed, evidenced 24 hour paracetamol charted QID (regular medications) and PRN tablets had been given prior to prescribed frequency and over maximum dose recommended within 24 hour timeframe (signing sheet documented five doses given within 24 hours). (iii) Controlled drug register reviewed did not document weekly checks or six monthly pharmacy checks. (iv) The fridge (hospital treatment room) used to store medications had no documented fridge temperatures. (v) Two expired medications (GTN sprays) were located on the hospital medication trolley.</p>	<p>(ii) Ensure that all medication administered has been signed by the prescriber. (iii) Ensure the controlled drug register is completed as per required legislation. (iv) Ensure all medications are stored as per required legislation. (v) Ensure all expired medications are disposed of as per required legislation.</p> <p>60 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The registered nurses interviewed confirmed that interventions are documented in the care plan for all assessed care needs. However, in the files sampled, interventions for all assessed care needs had not been documented to reflect current support needs.</p>	<p>Six (four hospital, one dementia and one rest home) of seven long term resident files sampled did not have documented interventions to address current assessed needs: i)One hospital resident with spinal injury did not have interventions or LTCP documented. ii)One resident in the dementia unit (tracer) with pressure injury. The care plan did not include interventions for pressure injury prevention/management, current activities of daily living, falls prevention and pain management. (iii)One hospital resident (tracer) with diabetes did not have interventions to manage hypo/hyperglycaemia</p>	<p>Ensure that all resident files have documented interventions to guide care.</p> <p>60 days</p>

			<p>or pressure area prevention.</p> <p>(iv)One hospital resident's file did not document ostomy care as directed by the ostomy nurse.</p> <p>(v)One rest home resident (tracer) at risk of wandering did not have documented interventions (including de-escalation and distraction techniques) for management of behaviour.</p> <p>(vi)Two resident files (one rest home and one dementia) did not have diversional therapy plans documented.</p>	
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>Maintenance systems are in place. Preventative maintenance schedules are maintained. Reactive maintenance issues are recorded and the maintenance person and facility manager interviewed were aware of the maintenance work required.</p>	<p>(i) One communal bathroom had a wooden shower seat to be replaced. Another communal bathroom had broken wall panelling requiring repair.</p> <p>(ii) One resident bedroom in the hospital wing had peeling ceiling paint and damaged skirting requiring repair.</p>	<p>Ensure all reactive maintenance issues are addressed and comply with legislation.</p> <p>90 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Moderate	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills are scheduled every six months. The orientation programme and annual education and training programme include fire and security training (link to finding 1.2.7.5). There is a minimum of one staff available seven days a week with a current first aid/CPR certificate on the am and pm shifts but not on the night shift.</p>	<p>There is a minimum of one staff available seven days a week with a current first aid/CPR certificate on the am and pm shifts but not on the night shift</p>	<p>Ensure there is a person trained in first aid across 24/7</p> <p>60 days</p>

<p>Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA Moderate</p>	<p>There are not enough call bell cords to ensure all residents can have access to their call bell when in bed. The upgrade in the call bell system does not provide suitable access in the rest home wing to a call bell in each of the two showers.</p>	<p>Maintenance staff reported that they were in need of four additional call bell cords in order to ensure that all residents have access to a call bell when lying in bed. It was also noted that in the rest home shower area, where there was previously a call bell cord accessible in each of the showers, there currently is only one call bell just outside of the two showers with a cord that requires residents (if showering independently) to remember to take the call bell into the shower with them. Staff reported that there are currently two rest home residents who are able to shower independently.</p>	<p>Ensure a call bell is readily accessible to all residents while in bed and when showering.</p> <p>60 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.